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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02339

CERTIFICATE OF DEATH

Reg. Dist. No.

2349

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FUNKSTOWN d. STREET ADDRESS 24 E. GREEN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUDREY Middle MAXINE Last ANGLE		4. DATE OF DEATH Month 2 Day 10 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 17, 1911
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IRA T. ANGLE SR.		14. MOTHER'S MAIDEN NAME SALLY BANKARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-16-3870	
17. INFORMANT MRS. RAY HENNINGER		Address FUNKSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of primary metastases to liver, abdomen + lungs. 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases to liver, abdomen + lungs. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH Sept 18-1958			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 18, 1958 , to July 10, 1959 , that I last saw the deceased alive on July 10, 1959 , and that death occurred at 6:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 24 E. Green St. Funkstown, MD. DATE SIGNED 2/13/59 ACTUAL SIGNATURE Sidney Novenstein PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/12/59	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS HAGERSTOWN, MD.		24a. REC'D BY REGISTRAR DATE FEB 13 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraiss

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF INTERVIEWER		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
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49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER	
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91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWER	
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97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	

U.S.A.

CONTENT

100-10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2350

CERTIFICATE OF DEATH

02340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles F Athey		4. DATE OF DEATH Month Day Year 2 26 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY W. Md. R. R.	
11. BIRTHPLACE (State or foreign country) Parsons, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas M. Athey		14. MOTHER'S MAIDEN NAME Ida Mae Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-10-7432	
17. INFORMANT Mrs. Anna J. Athey		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Esophagus (c) General Metastases		INTERVAL BETWEEN ONSET AND DEATH 6 MW	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1-58 , 19____, to 2-26 , 19 59 , that I last saw the deceased alive on 2-25-59 , 19____, and that death occurred at 6 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) DATE SIGNED [Signature] 2/26/59	
PHYSICIAN'S NAME (Type) [Signature]		M.D. [Signature]	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3-1-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

3380

RECEIVED
BALTIMORE
JAN 10 1910

DECEASED
A. B. W. M. 30

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2351

CERTIFICATE OF DEATH

Reg. Dist. No.

02341

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Smithsburg	
		f. STREET ADDRESS Smithsburg #2	
3. NAME OF DECEASED (Type or print) First Earl Middle Roy Last Bachtell		4. DATE OF DEATH Month Feb. Day 14 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Farmer		10b. KIND OF BUSINESS OR INDUSTRY Near Smithsburg	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David H. Bachtell		14. MOTHER'S MAIDEN NAME Selena Barkdoll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 215-36-5947A.	
17. INFORMANT David E. Bachtell, Smithsburg Md., Route 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 4 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-12 , 19 59 , to 2-14 , 19 59 , that I lost saw the deceased alive on 2-14 , 19 59 , and that death occurred at 11:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		ADDRESS (Street, city or town, state) DATE SIGNED 2-15-59	
PHYSICIAN'S NAME (Type) Charles F. Hess		Smithsburg Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/17/59	22c. NAME OF CEMETERY OR CREMATORY Smithsburg	22d. LOCATION (City, town, or county) (State) Smithsburg, Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Waynesboro Pa.		24a. REC'D BY REGISTRAR DATE FEB 18 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2024

DEATH CERTIFICATE

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BATHING BEACHES

<p>1. Name of Deceased: <u>JOHN J. SMITH</u></p>	
<p>2. Date of Death: <u>10/25/2024</u></p>	
<p>3. Place of Death: <u>At Home</u></p>	
<p>4. Age at Death: <u>78</u> Years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Cause of Death: <u>Heart Disease</u></p>	
<p>8. Date of Burial: <u>10/27/2024</u></p>	
<p>9. Place of Burial: <u>St. John's Cemetery</u></p>	
<p>10. Signature of Physician: <u>[Signature]</u></p>	
<p>11. Signature of Registrar: <u>[Signature]</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2,10,13,14 Film 6259 3-2-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hosp.</u>				d. STREET ADDRESS <u>Kang Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>Agnes</u> Middle <u>Barnes</u> Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 7, 1891</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Bedford Co Penn.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Dennis Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Lavine Cavendar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dennis Jay Barnes</u> Address <u>Clearville, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatous</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Ovary</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 15, 1950</u> , to <u>Feb 20, 1959</u> , that I last saw the deceased alive on <u>Feb 20, 1959</u> , and that death occurred at <u>5:20 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Moran</u> M.D.				ADDRESS (Street, city or town, state) <u>215 W Washington St</u> DATE SIGNED <u>2/20/59</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A. MORAN MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/23/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Bedford Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lyndard Barnes Everett Pa</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>FEB 24 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF NEXT OF KIN</p> <p>20. SIGNATURE OF BURIAL OFFICIAL</p> <p>21. SIGNATURE OF FUNERAL HOME</p> <p>22. SIGNATURE OF CHURCH</p> <p>23. SIGNATURE OF CEMETERY</p> <p>24. SIGNATURE OF OTHER</p>		<p>25. NAME OF PHYSICIAN</p> <p>26. ADDRESS OF PHYSICIAN</p> <p>27. CITY OF PHYSICIAN</p> <p>28. STATE OF PHYSICIAN</p> <p>29. ZIP CODE OF PHYSICIAN</p> <p>30. NAME OF REGISTRAR</p> <p>31. ADDRESS OF REGISTRAR</p> <p>32. CITY OF REGISTRAR</p> <p>33. STATE OF REGISTRAR</p> <p>34. ZIP CODE OF REGISTRAR</p> <p>35. NAME OF WITNESSES</p> <p>36. ADDRESS OF WITNESSES</p> <p>37. CITY OF WITNESSES</p> <p>38. STATE OF WITNESSES</p> <p>39. ZIP CODE OF WITNESSES</p> <p>40. NAME OF DECEASED</p> <p>41. ADDRESS OF DECEASED</p> <p>42. CITY OF DECEASED</p> <p>43. STATE OF DECEASED</p> <p>44. ZIP CODE OF DECEASED</p> <p>45. NAME OF NEXT OF KIN</p> <p>46. ADDRESS OF NEXT OF KIN</p> <p>47. CITY OF NEXT OF KIN</p> <p>48. STATE OF NEXT OF KIN</p> <p>49. ZIP CODE OF NEXT OF KIN</p> <p>50. NAME OF BURIAL OFFICIAL</p> <p>51. ADDRESS OF BURIAL OFFICIAL</p> <p>52. CITY OF BURIAL OFFICIAL</p> <p>53. STATE OF BURIAL OFFICIAL</p> <p>54. ZIP CODE OF BURIAL OFFICIAL</p> <p>55. NAME OF FUNERAL HOME</p> <p>56. ADDRESS OF FUNERAL HOME</p> <p>57. CITY OF FUNERAL HOME</p> <p>58. STATE OF FUNERAL HOME</p> <p>59. ZIP CODE OF FUNERAL HOME</p> <p>60. NAME OF CHURCH</p> <p>61. ADDRESS OF CHURCH</p> <p>62. CITY OF CHURCH</p> <p>63. STATE OF CHURCH</p> <p>64. ZIP CODE OF CHURCH</p> <p>65. NAME OF CEMETERY</p> <p>66. ADDRESS OF CEMETERY</p> <p>67. CITY OF CEMETERY</p> <p>68. STATE OF CEMETERY</p> <p>69. ZIP CODE OF CEMETERY</p> <p>70. NAME OF OTHER</p> <p>71. ADDRESS OF OTHER</p> <p>72. CITY OF OTHER</p> <p>73. STATE OF OTHER</p> <p>74. ZIP CODE OF OTHER</p>
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CERTIFICATE OF DEATH

Reg. Dist. No.

02343

2353

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ALBERT Last BECK				4. DATE OF DEATH Month FEBRUARY Day 13 Year 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/3/1891	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY CITY WATER PLANT			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME J. FRANK BECK				14. MOTHER'S MAIDEN NAME BLANCHE HARTLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or date of service) W.W.#1				16. SOCIAL SECURITY NO. 214-09-2250			
17. INFORMANT MRS. MABLE D. BECK				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma tongue 141.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) w/lt metastasis to neck & DUE TO (c) cervical region PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 30 , 19 58 , to Feb 13 , 19 59 , that I last saw the deceased alive on Feb 12 , 19 59 , and that death occurred at 1:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington St. DATE SIGNED 2-14-59 ACTUAL SIGNATURE Edward W. Ditto III M.D. PHYSICIAN'S NAME (Type) Edward W. Ditto III M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2/15/59			
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.				22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.			
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE FEB 16 '59			
24b. REGISTRAR'S SIGNATURE Charles E. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02344

2354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 65 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 6 W. IRVIN AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAMLIE Middle ELIZABETH Last BENTZ		4. DATE OF DEATH Month FEBRUARY Day 3 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1868
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM D. SPIKER		14. MOTHER'S MAIDEN NAME MARTHA VIRGINIA MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. PAULINE MEREDITH		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular dis. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 5 days years	
21. I certify that I attended the deceased from 6 July , 19 51 , to 3 Feb , 19 59 , that I last saw the deceased alive on 3 Feb , 19 59 , and that death occurred at 7:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) HAGERSTOWN, MARYLAND DATE SIGNED 4 FEBRUARY 59			
ACTUAL SIGNATURE Richard T. Binford			
PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/7/59	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE FEB 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2355

CERTIFICATE OF DEATH

Reg. Dist. No.

02345

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 34 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 18 Wabash Ave.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul Henry Blair Sr.				4. DATE OF DEATH Month February Day 3 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH June 16, 1910		9. AGE (In years lost birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Clearspring Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Percy Blair				14. MOTHER'S MAIDEN NAME Nora Hull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ----		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-09-5051		17. INFORMANT Mrs. Mary E. Blair		Address Hagerstown md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO occlusion of right Coronary Artery with Gangrene peri - thick - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple pulmonary emboli DUE TO nephrosclerosis - advanced - Diabetic mellitus (c) Diabetic mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3-4 yrs						INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from June 1, 1956 , to Feb 3, 1959 , that I last saw the deceased alive on Feb 2, 1959 , and that death occurred at 8:15a M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto				ADDRESS (Street, city or town, state) 217 W. Washington St.		DATE SIGNED 2-4-59	
PHYSICIAN'S NAME (Type) Edward W. Ditto III				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-59		22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Near Clearspring Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '59	
				24b. REGISTRAR'S SIGNATURE Chas. S. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2417

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		/ d. STREET ADDRESS 125 East Washington Street	
3. NAME OF DECEASED (Type or print) ANNIE First CATHERINE Middle BLOOM Last		4. DATE OF DEATH February Month 3 Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1869
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Heckman		14. MOTHER'S MAIDEN NAME Frederika Dummel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Ray Heckman Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse Atherosclerosis DUE TO yrs (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 12-1 , 19 59 , to 2-3 , 19 59 , that I last saw the deceased alive on 2-3 , 19 59 , and that death occurred at 6:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE M Byrd M.D. 28 W Potomac 2-5-59 PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/1959	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Franklin Ringer		24a. REC'D BY REGISTRAR DATE FEB 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

302

Name of Deceased		John J. [illegible]	
Age		[illegible]	
Sex		Male	
Race		White	
Marital Status		Married	
Occupation		[illegible]	
Cause of Death		[illegible]	
Date of Death		[illegible]	
Place of Death		[illegible]	
Signature of Physician		[illegible]	
Signature of Registrar		[illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02347

2418

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Middleburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Greencastle 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RFD 2	
3. NAME OF DECEASED (Type or print) Charles First Walter Middle Bonebrake Last		4. DATE OF DEATH Month Feb. Day 24, Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1906
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Bonebrake		14. MOTHER'S MAIDEN NAME Lucy Hahn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-6769	
17. INFORMANT Reba M. Bonebrake, Greencastle, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH suddenly
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/24/59 , 19____, to 2/24/59 , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 N. Potomac St. Hagerstown, Maryland DATE SIGNED 2/25/59			
ACTUAL SIGNATURE Howard N. Weeks		M.D. Howard N. Weeks, M.D.	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2-27-59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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2356

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|---|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | | | d. STREET ADDRESS
728 Frederick St | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
HARVEY LESUSTER BOWARD | | | | 4. DATE OF DEATH
Month Day Year
Feb. 6 19 59 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 6, 1888 | | 9. AGE (In years last birthday)
71 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bricklayer | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Hagerstown, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James W. Boward | | | | 14. MOTHER'S MAIDEN NAME
Helen Cline | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
214-09-2933 | | 17. INFORMANT
Harry L. Boward 728 Frederick St. Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolus
260 x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis
DUE TO
(c) Diabetes
INTERVAL BETWEEN ONSET AND DEATH
1 d
1 d
10 yrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Nephrosclerosis Ascites | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 2-2-59, to 2-6-59, that I last saw the deceased alive on 2-6-59, 1959, and that death occurred at 6:40 M. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE
J R Dwyer | | | | M.D. 2-5-59 | | | |
| PHYSICIAN'S NAME (Type)
J R Dwyer | | | | Hagerstown Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/9/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Rest Haven Funeral Chapel Inc. Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 10 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02340

2419

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Williamsport | | c. LENGTH OF STAY IN 1b
78 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
132½ S. Vermont Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Daisy Middle Alice Last Bowers | | 4. DATE OF DEATH
Month Feb. Day 10 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 11 1880 |
| 9. AGE (In years last birthday) yrs.
78 | | IF UNDER 1 YEAR
Months 6 Days 29 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
Andrew Blair | | 14. MOTHER'S MAIDEN NAME
Amanda Watson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Nellie Rancourt | | Address
238 N. Lucerne St. Baltimore, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Colony Brown/Bois
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immediate
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/10/59 to 2/10/59 , that I last saw the deceased alive on 2/10/59 , and that death occurred at 4:30 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Williamsport, Md. DATE SIGNED 4/14/59 | | | |
| ACTUAL SIGNATURE William Spaulding M.D. | | PHYSICIAN'S NAME (Type) William Spaulding | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 13-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Riverview Cemetery | | 22d. LOCATION (City, town, or county) (State)
Williamsport Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Arthur S. Kraus | | ADDRESS
Williamsport, Md. | |
| 24a. REC'D BY REGISTRAR
DATE FEB 16 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2357

2357

02350

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md
c. LENGTH OF STAY IN 1b 3 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hancock Rural 2
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First Middle Last Martha Deborah Breen
4. DATE OF DEATH Month Day Year 2 15 19 59
5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ B. DATE OF BIRTH May 12.1868
9. AGE (In years last birthday) 90 yrs. 9 Months 3 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington County Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Breen
14. MOTHER'S MAIDEN NAME Catherine Dillon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mary M Mills Hancock Md. Address
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Arterio Sclerotic Heart Dis
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 13, 1953, to Feb. 15, 1959, that I last saw the deceased alive on Feb. 13, 1959, and that death occurred at 4:50 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE David R. Brewer M.D. ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 2/17/59
PHYSICIAN'S NAME (Type) David R. Brewer
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2.18.59
22c. NAME OF CEMETERY OR CREMATOR St. Peters Catholic
22d. LOCATION (City, town, or county) (State) Hancock Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REC'D BY REGISTRAR
24b. REGISTRAR'S SIGNATURE
DATE FEB 24 '59

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES J. JONES | | M | | 45 | | JAN 15 1905 | | NEW YORK CITY | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| 1234 E. 10th St. | | Carpenter | | Heart Disease | | Natural | | New York City | |
| DATE OF DEATH | | TIME OF DEATH | | HOURS | | MINUTES | | PLACE OF DEATH | |
| JAN 20 1950 | | 10:15 AM | | 10 | | 15 | | New York City | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| J. J. Jones | | J. J. Jones | | J. J. Jones | | J. J. Jones | | J. J. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, Film G239 3-9-59 et

2358

CERTIFICATE OF DEATH

Reg. Dist. No.

02351

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN, MARYLAND
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
WESTERN MD STATE HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
KENSINGTON, MARYLAND 15X-2
d. STREET ADDRESS
10713 SHAFTSBURY ST
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
FANNIE LEE BROWN | | 4. DATE OF DEATH
Month Day Year
Feb. 25, 1959 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/6/1906 |
| 9. AGE (In years last birthday)
52 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DOMESTIC | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
WINTERGREEN, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
MARSHALL STEWART | | 14. MOTHER'S MAIDEN NAME
ELIZA TURNER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
STANLEY LOVE | | Address
KENSINGTON, MD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Empyema
576x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Liver abscess
DUE TO Sub diaphragmatic abscess
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
carcinoma of head of pancreas | | INTERVAL BETWEEN ONSET AND DEATH
5 days
4 mos.
6 mos | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 5 , 19 59 , to Feb. 25 , 19 59 , that I last saw the deceased alive on Feb. 25 , 19 59 , and that death occurred at 9:15 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) western md. State Hospital
DATE SIGNED | | | |
| ACTUAL SIGNATURE Victor L. Ramos | | M.D. western md. State Hospital | |
| PHYSICIAN'S NAME (Type) VICTOR L. RAMOS | | Hagerstown, MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
2/28/59 | 22c. NAME OF CEMETERY OR CREMATORY
GLEN MARY CEMETERY | 22d. LOCATION (City, town, or county) (State)
WINTER GREEN VIRGINIA |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Handen | | ADDRESS Rockville Md. | |
| 24a. REC'D BY REGISTRAR
MAR 3 '59 | | 24b. REGISTRAR'S SIGNATURE
Carling L. Hume | |

CERTIFICATE OF DEATH

REG. 101-102

DEATH OF _____

DATE OF DEATH _____

PLACE OF DEATH _____

CAUSE OF DEATH _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

DATE OF DEATH _____

PLACE OF DEATH _____

CAUSE OF DEATH _____

DATE OF BIRTH _____

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CAUSE OF DEATH _____

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PLACE OF DEATH _____

CAUSE OF DEATH _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

CONFIDENTIAL

MAINTAIN STATE DEPARTMENT OF HEALTH - BATHING 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2359

CERTIFICATE OF DEATH

Reg. Dist. No.

02352

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HAGERSTOWN</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>03 HAGERSTOWN</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Washington County DCA Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>LOUIS AUGUSTA BRUMBAUGH</u> | | 4. DATE OF DEATH Month Day Year
<u>FEBRUARY 6 1959</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>13 JUNE 1895</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>BAKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>BREAD</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>WEST VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>John BRUMBAUGH</u> | | 14. MOTHER'S MAIDEN NAME
<u>NANNIE SECKMAN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
<u>234-01-8247</u> | |
| 17. INFORMANT
<u>Mrs. Marie Brumbaugh</u> | | Address <u>819 Washington Ave HAGERSTOWN, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>general arteriosclerosis and</u>
(c) <u>arteriosclerotic heart disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Immed</u>
<u>10 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2/4</u> 19 <u>59</u> , to <u>2/6/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/4</u> 19 <u>59</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. | | ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown, Maryland</u> | |
| PHYSICIAN'S NAME (Type) <u>Edward W. Ditto 111 M.D.</u> | | DATE SIGNED <u>2-9-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 22b. DATE THEREOF
<u>9 FEB. 1959</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>ROSEDALE</u> | 22d. LOCATION (City, town, or county) (State)
<u>MARTINSBURG, W. VA.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Andrew K. Coffman</u> | | ADDRESS
<u>Hagerstown, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>FEB 11 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hines</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

DECEASED

IN THE

ROOM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2360

CERTIFICATE OF DEATH

02353

Reg. Dist. No.

| | | | |
|--|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN, MD. | | c. LENGTH OF STAY IN 1b
FEW HOURS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X CLEAR SPRING, MD. ROUTE 1 | | d. STREET ADDRESS
1 NONE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
WASHINGTON COUNTY HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
JANNETTE DORTHY BURKETT | | 4. DATE OF DEATH
FEBRUARY 15 19 59 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 3, 1926 |
| 9. AGE (In years lost birthday)
32 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOME DUTIES | | 10b. KIND OF BUSINESS OR INDUSTRY
HOUSEWORK | |
| 11. BIRTHPLACE (State or foreign country)
CLEAR SPRING, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
QUINTER DANIEL KING | | 14. MOTHER'S MAIDEN NAME
ELLA LOUISE CURRY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
JOHN LESLIE BURKETT | | Address
CLEAR SPRING, MD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH
Immediate | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/15/59 to 2/15/59, that I last saw the deceased alive on 2/15/59, and that death occurred at 9:30 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
[Signature] | | ADDRESS (Street, city or town, state) DATE SIGNED
2/15/59 | |
| PHYSICIAN'S NAME (Type)
[Signature] | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
FEB 17, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
ST. PAULS CEM. | | 22d. LOCATION (City, town, or county) (State)
ST. PAULS, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John F. Clark | | ADDRESS
CLEAR SPRING, MD. | |
| 24a. REC'D BY REGISTRAR
DATE
FEB 18 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2361 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02354

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 17 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1004 HAMILTON BLVD. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
d. STREET ADDRESS 11126 HAMILTON BLVD.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
GEORGE CLYDE BURKHOLDER | | 4. DATE OF DEATH
Month FEBRUARY Day 3 Year 19 59 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/1/1890 |
| 9. AGE (In years last birthday)
68 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED SALESMAN | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA |
| 12. CITIZEN OF WHAT COUNTRY
U.S.A. | | 13. FATHER'S NAME
JOHN H. BURKHOLDER | |
| 14. MOTHER'S MAIDEN NAME
EMMA K. BARTLES | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) YES (If yes, give year or date of service) W.W.#71 | |
| 16. SOCIAL SECURITY NO.
300-05-3319 | | 17. INFORMANT
Address HAGERSTOWN MD.
MRS. VIRGINIA BURKHOLDER | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) Cirrhosis of liver | | INTERVAL BETWEEN ONSET AND DEATH
10 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cirrhosis of liver | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
2-4-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
2/6/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEM. | | 22d. LOCATION (City, town, or county) (State)
HAGERSTOWN MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.J. Norman, Hagerstown, Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 9 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur E. Knapp | | | |

2362

CERTIFICATE OF DEATH

Reg. Dist. No. 02355

| | | | | | | | |
|--|---|---|---------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b
18 HOURS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
WASHINGTON COUNTY HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle JACOB Last BUSSARD | | | | 4. DATE OF DEATH
Month FEBRUARY Day 10 Year 1959 19 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 9 1874 | 9. AGE (In years last birthday)
84 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN FARM | | 11. BIRTHPLACE (State or foreign country)
SHARPSBURG WASH.CO.MD. U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
WILLIAM C. BUSSARD | | | | 14. MOTHER'S MAIDEN NAME
CHARLOTTE ANN AINSWORTH | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MARTIN L. RUSSARD SHARPSBURG MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis
450.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Acute Gastro-enteritis - Viral. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Sharpsburg, Md. | | (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 1, 1958 , to Feb. 11, 1959 , that I last saw the deceased alive on February 10, 1959 , and that death occurred at 10:45 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Walter H. Shealy | | | | ADDRESS (Street, city or town, state)
XXXXXX Sharpsburg, Md. | | | |
| PHYSICIAN'S NAME (Type)
Walter H. Shealy M. D. | | | | DATE SIGNED
2/11/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
FEB. 13 1959 | 22c. NAME OF CEMETERY OR CREMATORY
LOCUST GROVE CEMETERY | | 22d. LOCATION (City, town, or county) (State)
LOCUST GROVE WASH.CO.MD | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John H. East | | | | ADDRESS
BOONSBORO MD. | | 24a. REC'D BY REGISTRAR
FEB 13 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

2420

CERTIFICATE OF DEATH

02356

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|--|---|-----------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u> | | | | c. LENGTH OF STAY IN 1b <u>44 YEARS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R. 2</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>JOSIE</u> First Middle Last | | | | 4. DATE OF DEATH <u>FEBRUARY - 1 - 1959</u> Month Day Year | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY - 20 - 1865</u> | 9. AGE (In years last birthday) <u>93</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED OPERATOR OF BEAUTY SHOP.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BROOKLYN N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>ELIHU CONKLIN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ADELIA ANN GARDNER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>MRS. HERBERT DOLFIELD BOONSBORO MD.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.0</u> <u>Intermittent Heart</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 1959 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>Feb 1</u> , 1959, to <u>Feb 1</u> , 1959, that I last saw the deceased alive on <u>Feb 1</u> , 1959, and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>G. W. Wilson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Boonsboro</u> | | DATE SIGNED <u>2/2/59</u> | |
| PHYSICIAN'S NAME (Type) <u>G. W. Wilson</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>FEB. 3, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bass</u> ADDRESS <u>Boonsboro Md</u> | | | | 24a. REC'D BY REGISTRAR <u>FEB 5 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2363

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
35 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
16 Beckley Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Elizabeth Last Crosswhite | | | | 4. DATE OF DEATH
Month 2 Day 18 Year 19 59 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 25, 1883 | |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Home duties | | 11. BIRTHPLACE (State or foreign country)
Campbell Co. Tenn. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Home duties | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Campbell Co. Tenn. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Abner Lovely | | | | 14. MOTHER'S MAIDEN NAME
Lucinda Murray | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Jesse H. Crosswhite Address Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ovarian tumor with abdominal, pulmonary, and cervical metastasis and massive pleural effusion.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 234X (c) 234X
DUE TO (b) 234X (c) 234X | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
9 Months (certain) |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hypertensive cardiovascular disease | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Hagerstown | | | | 20g. (County)
Md. | | 20h. (State)
Md. | |
| 21. I certify that I attended the deceased from May 23, 1958 , to February 18, 1959 , that I last saw the deceased alive on February 17, 1959 , and that death occurred at 12:35 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. DATE SIGNED 2/18/59 | | | | | | | |
| ACTUAL SIGNATURE William T. Layman | | | | M.D. 100 Professional Arts Bldg. | | | |
| PHYSICIAN'S NAME (Type) William T. Layman, M.D. | | | | Hagerstown Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
2-20-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Fred W. Kraiss ADDRESS Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 19 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraiss | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

1900

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible] CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible] PLACE OF DEATH: [illegible]

NAME OF PHYSICIAN: [illegible] NAME OF FUNERAL HOME: [illegible]

SIGNATURE OF PHYSICIAN: [illegible] SIGNATURE OF FUNERAL HOME: [illegible]

DATE OF SIGNATURE: [illegible] PLACE OF SIGNATURE: [illegible]

NAME OF REGISTRAR: [illegible] NAME OF CLERK: [illegible]

DATE OF REGISTRATION: [illegible] PLACE OF REGISTRATION: [illegible]

NAME OF WITNESS: [illegible] NAME OF WITNESS: [illegible]

DATE OF WITNESS: [illegible] PLACE OF WITNESS: [illegible]

NAME OF WITNESS: [illegible] NAME OF WITNESS: [illegible]

DATE OF WITNESS: [illegible] PLACE OF WITNESS: [illegible]

NAME OF WITNESS: [illegible] NAME OF WITNESS: [illegible]

DATE OF WITNESS: [illegible] PLACE OF WITNESS: [illegible]

NAME OF WITNESS: [illegible] NAME OF WITNESS: [illegible]

DATE OF WITNESS: [illegible] PLACE OF WITNESS: [illegible]

NAME OF WITNESS: [illegible] NAME OF WITNESS: [illegible]

DATE OF WITNESS: [illegible] PLACE OF WITNESS: [illegible]

NAME OF WITNESS: [illegible] NAME OF WITNESS: [illegible]

DATE OF WITNESS: [illegible] PLACE OF WITNESS: [illegible]

NAME OF WITNESS: [illegible] NAME OF WITNESS: [illegible]

DATE OF WITNESS: [illegible] PLACE OF WITNESS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2364

CERTIFICATE OF DEATH

02358

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
13 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Garlock Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Aurah | | 4. DATE OF DEATH
Month 2 Day 18 Year 19 59 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 12, 1870 |
| 9. AGE (In years last birthday) yrs.
88 | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
home duties | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (State or foreign country)
Front Royal, Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Garmong | | 14. MOTHER'S MAIDEN NAME
Margaret Rogers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mrs. Grace Warren | | Address
Emmitsburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease.
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None. | | INTERVAL BETWEEN ONSET AND DEATH
Years. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 13, 1959 to Feb. 18, 1959 , that I last saw the deceased alive on Feb. 18, 1959 , and that death occurred at 8:00A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
R. A. Bell | | DATE SIGNED
Feb. 18, 1959 | |
| PHYSICIAN'S NAME (Type)
R. A. Bell, M. D. | | ADDRESS (Street, city or town, and state)
119 North Potomac St. Hagerstown, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
2-21-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Bunker Hill | | 22d. LOCATION (City, town, or county) (State)
Bunker Hill W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Fred W. Kraiss | | ADDRESS
Hagerstown, Md. | |
| 24a. REC'D BY REGISTRAR
FEB 24 1959 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraiss | |

UNIVERSITY OF CALIFORNIA

2365

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>03 Hagerstown</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Wash. County Hospital</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>NELLIE GERTRUDE CUNNINGHAM</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>February 16 19 59</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Feb'y 17 1880</u> | |
| 9. AGE (In years last birthday) yrs.
<u>78</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State, city or town)
<u>Rockingham Co Port Republic Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | 13. FATHER'S NAME
<u>Joshua Petre</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Mary Alice Brown</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>214-09-7608</u> | | | | 17. INFORMANT
Address
<u>Chester Cunningham 921 Frederick Road Hagerstown Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
<u>230X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Coronary Thrombosis</u>
DUE TO <u>Arteriosclerosis due to atherosclerosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 weeks</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
<u>Hagerstown</u> | | | | 20g. (County)
<u>Washington</u> | | 20h. (State)
<u>Md.</u> | |
| 21. I certify that I attended the deceased from <u>2-16-59</u> , to <u>2-16-59</u> , that I last saw the deceased alive on <u>2-16-59</u> , 19 <u>59</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>[Signature]</u> | | | | ADDRESS (Street, city or town, state)
<u>Hagerstown Md.</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>[Signature]</u> | | | | DATE SIGNED
<u>2/17/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/19/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Brethren Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Ringgold Wash. Co Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Andrew K. Coffman</u> | | | | ADDRESS
<u>Hagerstown Md.</u> | | 24a. REC'D BY REGISTRAR
DATE
<u>FEB 20 1959</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2382

WILLIAM ROYD

Age 70

| | | | | | | | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|----------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | |
| WILLIAM ROYD | | 70 | | Male | | White | | 1914 | | Maryland | |
| Cause of Death | | Duration of Illness | | Occupation | | Education | | Marital Status | | Religion | |
| Heart Disease | | Several Months | | Farmer | | High School | | Married | | Methodist | |
| Immediate Cause | | Period of Incubation | | Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | |
| Myocardial Infarction | | None | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Contributing Cause | | Period of Incubation | | Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | |
| Hypertension | | None | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Manner of Death | | Period of Incubation | | Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | |
| Natural | | None | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Suicide | | None | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Accident | | None | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Homicide | | None | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| Undetermined | | None | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

CERTIFICATE OF DEATH

Reg. Dist. No.

02360

2366

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN 1b 38 YRS. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1103 MT. ETNA ROAD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ISAAC First Middle MILTON Last DAVIS | | 4. DATE OF DEATH Month FEBRUARY Day 8 Year 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/5/1887 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION WORK MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH DAVIS | | 14. MOTHER'S MAIDEN NAME LYDIA WOLFORD | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT MRS. REBA M. DAVIS | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis
(c) Atherosclerosis of Heart
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH 6 min |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 2-1-59, 19 to 2-8-59, 19, that I last saw the deceased alive on 2-7-59, 19, and that death occurred at 10:11 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE H. E. W. Little | | DATE SIGNED 2/13/59 | |
| PHYSICIAN'S NAME (Type) H. E. W. Little | | ADDRESS Hagerstown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 2/11/59 | 22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM. | 22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman | | 24a. REC'D BY REGISTRAR DATE FEB 13 59 | |
| ADDRESS Hagerstown, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Evans | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3785

| | | | | | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED
EDWARD J. BROWN | | 2. SEX
MALE | | 3. AGE
45 | |
| 4. DATE OF DEATH
JAN 15 1918 | | 5. TIME OF DEATH
10:30 AM | | 6. PLACE OF DEATH
HOME | |
| 7. CAUSE OF DEATH
HEART DISEASE | | 8. DISEASE OR INJURY
CORONARY ARTERY DISEASE | | 9. PREVIOUS ILLNESS
NONE | |
| 10. OCCASION OF DEATH
SUDDEN | | 11. PLACE OF BIRTH
BOSTON, MASS. | | 12. DATE OF BIRTH
JAN 15 1873 | |
| 13. NAME OF PHYSICIAN
DR. J. B. BROWN | | 14. NAME OF FUNERAL HOME
J. B. BROWN | | 15. NAME OF BURIAL PLACE
CATHOLIC CEMETERY | |
| 16. NAME OF REGISTRAR
J. B. BROWN | | 17. NAME OF CLERK
J. B. BROWN | | 18. NAME OF ASSISTANT CLERK
J. B. BROWN | |
| 19. NAME OF DECEASED'S MOTHER
J. B. BROWN | | 20. NAME OF DECEASED'S FATHER
J. B. BROWN | | 21. NAME OF DECEASED'S SPOUSE
J. B. BROWN | |
| 22. NAME OF DECEASED'S CHILDREN
J. B. BROWN | | 23. NAME OF DECEASED'S BROTHERS
J. B. BROWN | | 24. NAME OF DECEASED'S SISTERS
J. B. BROWN | |
| 25. NAME OF DECEASED'S GRANDPARENTS
J. B. BROWN | | 26. NAME OF DECEASED'S UNCLE
J. B. BROWN | | 27. NAME OF DECEASED'S AUNT
J. B. BROWN | |
| 28. NAME OF DECEASED'S NEPHEW
J. B. BROWN | | 29. NAME OF DECEASED'S NIECE
J. B. BROWN | | 30. NAME OF DECEASED'S COUSIN
J. B. BROWN | |
| 31. NAME OF DECEASED'S FIRST COUNSELOR
J. B. BROWN | | 32. NAME OF DECEASED'S SECOND COUNSELOR
J. B. BROWN | | 33. NAME OF DECEASED'S THIRD COUNSELOR
J. B. BROWN | |
| 34. NAME OF DECEASED'S FOURTH COUNSELOR
J. B. BROWN | | 35. NAME OF DECEASED'S FIFTH COUNSELOR
J. B. BROWN | | 36. NAME OF DECEASED'S SIXTH COUNSELOR
J. B. BROWN | |
| 37. NAME OF DECEASED'S SEVENTH COUNSELOR
J. B. BROWN | | 38. NAME OF DECEASED'S EIGHTH COUNSELOR
J. B. BROWN | | 39. NAME OF DECEASED'S NINTH COUNSELOR
J. B. BROWN | |
| 40. NAME OF DECEASED'S TENTH COUNSELOR
J. B. BROWN | | 41. NAME OF DECEASED'S ELEVENTH COUNSELOR
J. B. BROWN | | 42. NAME OF DECEASED'S TWELFTH COUNSELOR
J. B. BROWN | |
| 43. NAME OF DECEASED'S THIRTEENTH COUNSELOR
J. B. BROWN | | 44. NAME OF DECEASED'S FOURTEENTH COUNSELOR
J. B. BROWN | | 45. NAME OF DECEASED'S FIFTEENTH COUNSELOR
J. B. BROWN | |
| 46. NAME OF DECEASED'S SIXTEENTH COUNSELOR
J. B. BROWN | | 47. NAME OF DECEASED'S SEVENTEENTH COUNSELOR
J. B. BROWN | | 48. NAME OF DECEASED'S EIGHTEENTH COUNSELOR
J. B. BROWN | |
| 49. NAME OF DECEASED'S NINETEENTH COUNSELOR
J. B. BROWN | | 50. NAME OF DECEASED'S TWENTIETH COUNSELOR
J. B. BROWN | | 51. NAME OF DECEASED'S TWENTY-FIRST COUNSELOR
J. B. BROWN | |
| 52. NAME OF DECEASED'S TWENTY-SECOND COUNSELOR
J. B. BROWN | | 53. NAME OF DECEASED'S TWENTY-THIRD COUNSELOR
J. B. BROWN | | 54. NAME OF DECEASED'S TWENTY-FOURTH COUNSELOR
J. B. BROWN | |
| 55. NAME OF DECEASED'S TWENTY-FIFTH COUNSELOR
J. B. BROWN | | 56. NAME OF DECEASED'S TWENTY-SIXTH COUNSELOR
J. B. BROWN | | 57. NAME OF DECEASED'S TWENTY-SEVENTH COUNSELOR
J. B. BROWN | |
| 58. NAME OF DECEASED'S TWENTY-EIGHTH COUNSELOR
J. B. BROWN | | 59. NAME OF DECEASED'S TWENTY-NINTH COUNSELOR
J. B. BROWN | | 60. NAME OF DECEASED'S THIRTIETH COUNSELOR
J. B. BROWN | |
| 61. NAME OF DECEASED'S THIRTY-FIRST COUNSELOR
J. B. BROWN | | 62. NAME OF DECEASED'S THIRTY-SECOND COUNSELOR
J. B. BROWN | | 63. NAME OF DECEASED'S THIRTY-THIRD COUNSELOR
J. B. BROWN | |
| 64. NAME OF DECEASED'S THIRTY-FOURTH COUNSELOR
J. B. BROWN | | 65. NAME OF DECEASED'S THIRTY-FIFTH COUNSELOR
J. B. BROWN | | 66. NAME OF DECEASED'S THIRTY-SIXTH COUNSELOR
J. B. BROWN | |
| 67. NAME OF DECEASED'S THIRTY-SEVENTH COUNSELOR
J. B. BROWN | | 68. NAME OF DECEASED'S THIRTY-EIGHTH COUNSELOR
J. B. BROWN | | 69. NAME OF DECEASED'S THIRTY-NINTH COUNSELOR
J. B. BROWN | |
| 70. NAME OF DECEASED'S FORTY COUNSELOR
J. B. BROWN | | 71. NAME OF DECEASED'S FORTY-FIRST COUNSELOR
J. B. BROWN | | 72. NAME OF DECEASED'S FORTY-SECOND COUNSELOR
J. B. BROWN | |
| 73. NAME OF DECEASED'S FORTY-THIRD COUNSELOR
J. B. BROWN | | 74. NAME OF DECEASED'S FORTY-FOURTH COUNSELOR
J. B. BROWN | | 75. NAME OF DECEASED'S FORTY-FIFTH COUNSELOR
J. B. BROWN | |
| 76. NAME OF DECEASED'S FORTY-SIXTH COUNSELOR
J. B. BROWN | | 77. NAME OF DECEASED'S FORTY-SEVENTH COUNSELOR
J. B. BROWN | | 78. NAME OF DECEASED'S FORTY-EIGHTH COUNSELOR
J. B. BROWN | |
| 79. NAME OF DECEASED'S FORTY-NINTH COUNSELOR
J. B. BROWN | | 80. NAME OF DECEASED'S FIFTY COUNSELOR
J. B. BROWN | | 81. NAME OF DECEASED'S FIFTY-FIRST COUNSELOR
J. B. BROWN | |
| 82. NAME OF DECEASED'S FIFTY-SECOND COUNSELOR
J. B. BROWN | | 83. NAME OF DECEASED'S FIFTY-THIRD COUNSELOR
J. B. BROWN | | 84. NAME OF DECEASED'S FIFTY-FOURTH COUNSELOR
J. B. BROWN | |
| 85. NAME OF DECEASED'S FIFTY-FIFTH COUNSELOR
J. B. BROWN | | 86. NAME OF DECEASED'S FIFTY-SIXTH COUNSELOR
J. B. BROWN | | 87. NAME OF DECEASED'S FIFTY-SEVENTH COUNSELOR
J. B. BROWN | |
| 88. NAME OF DECEASED'S FIFTY-EIGHTH COUNSELOR
J. B. BROWN | | 89. NAME OF DECEASED'S FIFTY-NINTH COUNSELOR
J. B. BROWN | | 90. NAME OF DECEASED'S SIXTY COUNSELOR
J. B. BROWN | |
| 91. NAME OF DECEASED'S SIXTY-FIRST COUNSELOR
J. B. BROWN | | 92. NAME OF DECEASED'S SIXTY-SECOND COUNSELOR
J. B. BROWN | | 93. NAME OF DECEASED'S SIXTY-THIRD COUNSELOR
J. B. BROWN | |
| 94. NAME OF DECEASED'S SIXTY-FOURTH COUNSELOR
J. B. BROWN | | 95. NAME OF DECEASED'S SIXTY-FIFTH COUNSELOR
J. B. BROWN | | 96. NAME OF DECEASED'S SIXTY-SIXTH COUNSELOR
J. B. BROWN | |
| 97. NAME OF DECEASED'S SIXTY-SEVENTH COUNSELOR
J. B. BROWN | | 98. NAME OF DECEASED'S SIXTY-EIGHTH COUNSELOR
J. B. BROWN | | 99. NAME OF DECEASED'S SIXTY-NINTH COUNSELOR
J. B. BROWN | |
| 100. NAME OF DECEASED'S SEVENTY COUNSELOR
J. B. BROWN | | 101. NAME OF DECEASED'S SEVENTY-FIRST COUNSELOR
J. B. BROWN | | 102. NAME OF DECEASED'S SEVENTY-SECOND COUNSELOR
J. B. BROWN | |
| 103. NAME OF DECEASED'S SEVENTY-THIRD COUNSELOR
J. B. BROWN | | 104. NAME OF DECEASED'S SEVENTY-FOURTH COUNSELOR
J. B. BROWN | | 105. NAME OF DECEASED'S SEVENTY-FIFTH COUNSELOR
J. B. BROWN | |
| 106. NAME OF DECEASED'S SEVENTY-SIXTH COUNSELOR
J. B. BROWN | | 107. NAME OF DECEASED'S SEVENTY-SEVENTH COUNSELOR
J. B. BROWN | | 108. NAME OF DECEASED'S SEVENTY-EIGHTH COUNSELOR
J. B. BROWN | |
| 109. NAME OF DECEASED'S SEVENTY-NINTH COUNSELOR
J. B. BROWN | | 110. NAME OF DECEASED'S EIGHTY COUNSELOR
J. B. BROWN | | 111. NAME OF DECEASED'S EIGHTY-FIRST COUNSELOR
J. B. BROWN | |
| 112. NAME OF DECEASED'S EIGHTY-SECOND COUNSELOR
J. B. BROWN | | 113. NAME OF DECEASED'S EIGHTY-THIRD COUNSELOR
J. B. BROWN | | 114. NAME OF DECEASED'S EIGHTY-FOURTH COUNSELOR
J. B. BROWN | |
| 115. NAME OF DECEASED'S EIGHTY-FIFTH COUNSELOR
J. B. BROWN | | 116. NAME OF DECEASED'S EIGHTY-SIXTH COUNSELOR
J. B. BROWN | | 117. NAME OF DECEASED'S EIGHTY-SEVENTH COUNSELOR
J. B. BROWN | |
| 118. NAME OF DECEASED'S EIGHTY-EIGHTH COUNSELOR
J. B. BROWN | | 119. NAME OF DECEASED'S EIGHTY-NINTH COUNSELOR
J. B. BROWN | | 120. NAME OF DECEASED'S NINETY COUNSELOR
J. B. BROWN | |
| 121. NAME OF DECEASED'S NINETY-FIRST COUNSELOR
J. B. BROWN | | 122. NAME OF DECEASED'S NINETY-SECOND COUNSELOR
J. B. BROWN | | 123. NAME OF DECEASED'S NINETY-THIRD COUNSELOR
J. B. BROWN | |
| 124. NAME OF DECEASED'S NINETY-FOURTH COUNSELOR
J. B. BROWN | | 125. NAME OF DECEASED'S NINETY-FIFTH COUNSELOR
J. B. BROWN | | 126. NAME OF DECEASED'S NINETY-SIXTH COUNSELOR
J. B. BROWN | |
| 127. NAME OF DECEASED'S NINETY-SEVENTH COUNSELOR
J. B. BROWN | | 128. NAME OF DECEASED'S NINETY-EIGHTH COUNSELOR
J. B. BROWN | | 129. NAME OF DECEASED'S NINETY-NINTH COUNSELOR
J. B. BROWN | |
| 130. NAME OF DECEASED'S HUNDRED COUNSELOR
J. B. BROWN | | 131. NAME OF DECEASED'S HUNDRED-FIRST COUNSELOR
J. B. BROWN | | 132. NAME OF DECEASED'S HUNDRED-SECOND COUNSELOR
J. B. BROWN | |
| 133. NAME OF DECEASED'S HUNDRED-THIRD COUNSELOR
J. B. BROWN | | 134. NAME OF DECEASED'S HUNDRED-FOURTH COUNSELOR
J. B. BROWN | | 135. NAME OF DECEASED'S HUNDRED-FIFTH COUNSELOR
J. B. BROWN | |
| 136. NAME OF DECEASED'S HUNDRED-SIXTH COUNSELOR
J. B. BROWN | | 137. NAME OF DECEASED'S HUNDRED-SEVENTH COUNSELOR
J. B. BROWN | | 138. NAME OF DECEASED'S HUNDRED-EIGHTH COUNSELOR
J. B. BROWN | |
| 139. NAME OF DECEASED'S HUNDRED-NINTH COUNSELOR
J. B. BROWN | | 140. NAME OF DECEASED'S HUNDRED-TENTH COUNSELOR
J. B. BROWN | | 141. NAME OF DECEASED'S HUNDRED-ELEVENTH COUNSELOR
J. B. BROWN | |
| 142. NAME OF DECEASED'S HUNDRED-TWELFTH COUNSELOR
J. B. BROWN | | 143. NAME OF DECEASED'S HUNDRED-THIRTEENTH COUNSELOR
J. B. BROWN | | 144. NAME OF DECEASED'S HUNDRED-FOURTEENTH COUNSELOR
J. B. BROWN | |
| 145. NAME OF DECEASED'S HUNDRED-FIFTEENTH COUNSELOR
J. B. BROWN | | 146. NAME OF DECEASED'S HUNDRED-SIXTEENTH COUNSELOR
J. B. BROWN | | 147. NAME OF DECEASED'S HUNDRED-SEVENTEENTH COUNSELOR
J. B. BROWN | |
| 148. NAME OF DECEASED'S HUNDRED-EIGHTEENTH COUNSELOR
J. B. BROWN | | 149. NAME OF DECEASED'S HUNDRED-NINETEENTH COUNSELOR
J. B. BROWN | | 150. NAME OF DECEASED'S HUNDRED-TWENTY COUNSELOR
J. B. BROWN | |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BATHING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2367

CERTIFICATE OF DEATH

Reg. Dist. No.

02361

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
4 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Wash. Co. Hospital | | e. STREET ADDRESS
812 Spruce St., | |
| 3. NAME OF DECEASED (Type or print)
First Lawrence Middle Ray Last Davis | | 4. DATE OF DEATH
Month 2 Day 7 Year 19 59 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 3, 1888 |
| 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | 10b. KIND OF BUSINESS OR INDUSTRY
W. Md. R.R. | 11. BIRTHPLACE (State or foreign country)
Virginia |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Summerfield Davis | |
| 14. MOTHER'S MAIDEN NAME
Mary Frazier | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
yes W.W. I | |
| 16. SOCIAL SECURITY NO.
705-10-5959 | | 17. INFORMANT
Address
Mrs. Clara Mae Davis Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 527.1 marked emphysema & resp. failure 6 months +
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Arteriosclerosis, adhesions in abd. | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 17 OCTOBER, 1956 , to 7 FEBRUARY, 1959 , that I last saw the deceased alive on 7 FEBRUARY, 1959 , and that death occurred at 3:58 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Richard T. Binford | | ADDRESS (Street, city or town, state)
Md. 1135 POTOMAC AVENUE, HAGERSTOWN, Md. | |
| PHYSICIAN'S NAME (Type)
RICHARD T. BINFORD, M. D. | | DATE SIGNED
2/9/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 22b. DATE THEREOF
2-10-59 | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Fred W. Kraiss | | ADDRESS
Hagerstown, Md. | |
| 24a. REC'D BY REGISTRAR
FEB 13 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Hanna | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02362

2368

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cecilton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Garlock Nursing Home | | d. STREET ADDRESS
07x-2 | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Robert Chester De Lauder | | 4. DATE OF DEATH Month Day Year
February 27 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 7, 1880 |
| 9. AGE (In years last birthday) yrs.
78 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY
Repair | |
| 11. BIRTHPLACE (State or foreign country)
Near Middletown Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Robert S. De Lauder | | 14. MOTHER'S MAIDEN NAME
Ada F. Barrick | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
---- | | 16. SOCIAL SECURITY NO.
214-16-0621 | |
| 17. INFORMANT
J. Robert De Lauder | | Address
Galena Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of rectum; Acute bronchitis and
154X DUE TO acute myocardial failure
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
30 hrs | | | INTERVAL BETWEEN ONSET AND DEATH
30 hrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. None 19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | 20f. (City or town) (County) (State)
- - - |
| 21. I certify that I attended the deceased from Oct. , 19 58 , to Feb. 27 , 19 59 , that I last saw the deceased alive on Feb. 27 , 19 59 , and that death occurred at 5:10 P. M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
S. Robert Wells M.D. 115 N. Potomac Street 2-28-59
Hagerstown, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3-2-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Christ Reformed | | 22d. LOCATION (City, town, or county) (State)
Middletown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Scott F. Minnich & Son | | 24a. REC'D BY REGISTRAR
MAR 4 '59 | |
| ADDRESS
Hagerstown Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. K... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2369 CERTIFICATE OF DEATH

02363

Reg. Dist. No. 302

| | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
Few minutes | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Washington County Hospital | | | | d. STREET ADDRESS
205 East Lincoln Ave. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Brenda Middle Ann Last Delouney | | | | 4. DATE OF DEATH
Month February Day 19 Year 19 59 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 19, 1959 | |
| 9. AGE (In years last birthday)
yrs. | | IF UNDER 1 YEAR
Months | | IF UNDER 24 HRS.
Days | | Hours | |
| | | | | | | Min. 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Hagerstown, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Charles Delouney | | | | 14. MOTHER'S MAIDEN NAME
Betty Jane Kelly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address
Mr. Charles Delouney Hagerstown, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776X DUE TO Immaturity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Premature Delivery DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
30 MINS
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 2/19 , 19 59 , to 2/19 , 19 59 , that I last saw the deceased alive on 2/19 , 19 59 , and that death occurred at 5:30 A. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Hagerstown, Md DATE SIGNED 2/20/59 | | | | | | | |
| ACTUAL SIGNATURE Richard A. Young M.D. | | | | PHYSICIAN'S NAME (Type) Richard A. Young | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
2/20/1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | |
| 22d. LOCATION (City, town, or county)
Hagerstown, Maryland | | | | 22e. (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R. L. Lankford | | | | ADDRESS
Hagerstown, Md. | | 24a. REC'D BY REGISTRAR
FEB 24 1959 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kneass | | | | 24c. (City, town, or county) | | 24d. (State) | |

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2370

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
9 hours | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Linda Middle Sue Last Delouney | | 4. DATE OF DEATH
Month February Day 19 Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 19, 1959 |
| 9. AGE (In years last birthday) yrs. 9 | | IF UNDER 1 YEAR Months 9 Days 9 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Hagerstown, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Delouney | | 14. MOTHER'S MAIDEN NAME
Betty Jane Kelly | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mr. Charles Delouney | | Address
Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776X DUE TO Immaturity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prenatal delay DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
9 hrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from 2/19 , 19 59 , to 2/19 , 19 59 , that I last saw the deceased alive on 2/19 , 19 59 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. | |
| ACTUAL SIGNATURE Richard A. Young M.D. | | ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 2/20/59 | |
| PHYSICIAN'S NAME (Type) Richard A. Young | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/20/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R. Franklin Rizer | | 24a. REC'D BY REGISTRAR
DATE FEB 24 '59 | |
| ADDRESS
Hagerstown, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2281266XVO

CERTIFICATE OF DEATH

2273

202

7-4-7

Residence

Married

Married

Married

Married

Married

202 West Lincoln Ave.

Married on County Hospital

Married

Married

Married

Married

Married 12, 1919

White

Male

None

Married

Married

Married

Married

None

0

0

Married

Married

2 TO 1920

Married

Married

Married

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2371

CERTIFICATE OF DEATH

Reg. Dist. No. 302

02365

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 12 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital | | d. STREET ADDRESS 20 East Washington Street | |
| 3. NAME OF DECEASED (Type or print) AUGUSTUS First FREDERICK Middle DIENER Last | | 4. DATE OF DEATH February Month 8 Day 19 Year 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 13, 1871 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Jeweler | | 10b. KIND OF BUSINESS OR INDUSTRY Williamsport, Pennsylvania U.S.A. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Augustus F. Diener | | 14. MOTHER'S MAIDEN NAME Josephine Karn | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-14-7959 | |
| 17. INFORMANT Mrs. Bertha E. Diener Address Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
610X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prostatic hyperplasia
DUE TO with hemorrhage
(c) generalized arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 2 days
6 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 30, 1958 , to Feb 8, 1959 , that I last saw the deceased alive on Feb 8, 1959 , and that death occurred at 8:10 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph C. Crisp M.D. | | ADDRESS (Street, city or town, state) 115 King St. | |
| PHYSICIAN'S NAME (Type) Joseph C. Crisp, M. D. | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/11/1959 | 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | 22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sater-Rouzer Funeral Home | | ADDRESS Hagerstown, Md. | 24a. REC'D BY REGISTRAR FEB 13 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

30

Washington

Washington

Washington

Washington

12

Washington

Washington County Hospital

50 West Washington Street

ACUTE

INTERNAL

FEVER

February

Male

White

March 13, 1911

87

Retired Jeweler

Williamsport, Pennsylvania, U.S.A.

Amateur P. Player

Josephine Farm

no

1911-1-100

Rev. Father F. J. Player, Washington, D.C.

March 13, 1911, P.M.

Inter

2/1/1911

Next seven contacts

Inter

Inter

Inter-Player Funeral Home, Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2372

CERTIFICATE OF DEATH

Reg. Dist. No.

302

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b 60 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BERTHA BINGHAM DUNAHUGH | | 4. DATE OF DEATH Feby. 13 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Jany. 2 1873 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR: Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Urias W. Bingham | | 14. MOTHER'S MAIDEN NAME Susan Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----- | | 17. INFORMANT Mrs Miriam Highbarger Address 105 North Ave | |
| 16. SOCIAL SECURITY NO. None | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral arteriosclerosis
334X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-6-57 , 19 57 , to 12-13-59 , 19 59 , that I last saw the deceased alive on 2-12-59 , 19 59 , and that death occurred at 4:15 P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 318 N. Potomac St. Hagerstown, Md. DATE SIGNED 2-14-59 | | | |
| ACTUAL SIGNATURE Paul Harrison | | M.D. 318 N. Potomac St. Hagerstown, Md. | |
| PHYSICIAN'S NAME (Type) Paul Harrison, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/15/59 | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | 22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md. | | 24a. REC'D BY REGISTRAR FEB 17 '59 24b. REGISTRAR'S SIGNATURE Charles S. Kraus | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02367

2373

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
COUNTY
Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
Maryland
COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
03 Hagerstown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Wash. County Hospital | | d. STREET ADDRESS
1505 Fountain Hd. Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
NILES SPEANER EASTERDAY | | 4. DATE OF DEATH
Month Day Year
February 14 1959 19 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 15 1899 | | 9. AGE (In years last birthday) yrs. 59 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Service Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY
Pangborn Corp. | | 11. BIRTHPLACE (State or foreign country)
Md. | |
| 13. FATHER'S NAME
William Easterday | | 14. MOTHER'S MAIDEN NAME
Cecelia Gillis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
Mrs Isabell H. Easterday 1505 Ft Head Rd Hagerstown Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion
420.1 DUE TO Arteriosclerotic (coronary) heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
(c)
INTERVAL BETWEEN ONSET AND DEATH
9 days
2 1/2 years | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 8/6, 1956 to 2/14, 1959 , that I last saw the deceased alive on 2/14, 1959 , and that death occurred at 10:25 A.M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
John H. Hornbaker | | ADDRESS (Street, city or town, state)
154 West Washington St., Hagerstown, Md. | | | |
| DATE SIGNED
2:16:59 | | | | | |
| PHYSICIAN'S NAME (Type)
John H. Hornbaker, M.D. | | Hagerstown, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/17/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Wash. Co Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Andrew K. Coffman | | ADDRESS
Hagerstown Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 17 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
C. E. Kline | |



2374

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Washington
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
JAMES CRAIG ELLIOTT | | 4. DATE OF DEATH
Month February Day 17 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 18, 1893 |
| 9. AGE (In years last birthday)
65 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shipping clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Foundry | |
| 11. BIRTHPLACE (State or foreign country)
Welsh Run, Penn. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Frank T. Elliott | | 14. MOTHER'S MAIDEN NAME
Mary Alice Hacker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes W. W. I | | 16. SOCIAL SECURITY NO.
578-07-8459 | |
| 17. INFORMANT
Hrs. Helen B. Elliott Hagerstown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None. | | INTERVAL BETWEEN ONSET AND DEATH
16 hrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 17, 1959 , to Feb. 17, 1959 , that I last saw the deceased alive on Feb. 17, 1959 , and that death occurred at 6:57 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>R. A. Bell</i> | | ADDRESS (Street, city or town, state) DATE SIGNED
119 North Potomac St. Feb. 18, 1959. | |
| PHYSICIAN'S NAME (Type)
R. A. Bell, M.D. | | Hagerstown, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/ 20/ 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>H. Franklin Ruyter</i>
Suter-Rouzer Funeral Home | | ADDRESS
Hagerstown, Md. | |
| 24a. REC'D BY REGISTRAR
DATE
FEB 24 '59 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kline</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 100

DECEASED

NAME

RESIDENCE

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

PLACE OF DEATH

1

2

3

4

5

CAUSE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LOCUST GROVE RURAL | | | | c. LENGTH OF STAY IN 1b
38 YEARS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
ROHRERSVILLE MD. ROUTE 1 | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LOCUST GROVE RURAL | | | |
| f. STREET ADDRESS
ROHRERSVILLE MD. ROUTE 1 | | | | g. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First EARL Middle ESHELMAN Last ESHELMAN | | | | 4. DATE OF DEATH
Month FEBRUARY Day 16 Year 1959 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCTOBER 30 1882 | 9. AGE (In years last birthday)
76 yrs. | 10. IF UNDER 1 YEAR: Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (State or foreign country)
CANTON ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
MARTIN ESHELMAN | | | | 14. MOTHER'S MAIDEN NAME
AMELIA DEWITT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MISS MARTHA HAYNES ROHRERSVILLE MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO 420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb-16 , 19 59 , to Feb-16 , 19 59 , that I last saw the deceased alive on Feb-16 , 19 59 , and that death occurred at 8 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
G. W. Helman | | | | ADDRESS (Street, city or town, state)
Bonnsboro | | | |
| PHYSICIAN'S NAME (Type)
G. W. Helman | | | | DATE SIGNED
2/17/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
FEB. 19 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
LOCUST GROVE CEMETERY | | 22d. LOCATION (City, town, or county) (State)
LOCUST GROVE WASH. CO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John H. Best | | | | 24a. REC'D BY REGISTRAR
DATE FEB 20 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

| | | | | | | | | | |
|-----------------------------------|--|-----------------------------------|--|-----------------------------------|--|--|--|--------------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | | <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | | <p>5. PLACE OF BIRTH</p> | |
| <p>6. OCCUPATION</p> | | <p>7. CAUSE OF DEATH</p> | | <p>8. PLACE OF DEATH</p> | | <p>9. DATE OF DEATH</p> | | <p>10. TIME OF DEATH</p> | |
| <p>11. SIGNATURE OF PHYSICIAN</p> | | <p>12. SIGNATURE OF REGISTRAR</p> | | <p>13. SIGNATURE OF WITNESSES</p> | | <p>14. SIGNATURE OF DECEASED</p> | | <p>15. SIGNATURE OF NEXT OF KIN</p> | |
| <p>16. SIGNATURE OF CLERK</p> | | <p>17. SIGNATURE OF JUDGE</p> | | <p>18. SIGNATURE OF SHERIFF</p> | | <p>19. SIGNATURE OF TOWNSHIP CLERK</p> | | <p>20. SIGNATURE OF VOTING CLERK</p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2375

CERTIFICATE OF DEATH

Reg. Dist. No.

02370

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
1 1/2 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
155 S. Mulberry Street | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Keedysville RFD | | | |
| f. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Hugh Middle Oliver Last Fisher | | | | 4. DATE OF DEATH
Month Feb. Day 22 Year 1959 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 28 1885 | 9. AGE (In years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months 4 Days 4 Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret'd Farm Owner | | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | | 11. BIRTHPLACE (State or foreign country)
Eakles Mill Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A |
| 13. FATHER'S NAME
John A. Fisher | | | | 14. MOTHER'S MAIDEN NAME
Catherine Kefauver | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO.
215 20 8561 | | 17. INFORMANT
Mrs. Albert Bowers Address 12 Fourth Street Hagerstown Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Arteriosclerosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, General
(c) Diphtheritis, Acute, Colon | | | | | | INTERVAL BETWEEN ONSET AND DEATH
years
6 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Feb 1 , 19 59 , to Feb 22 , 19 59 , that I last saw the deceased alive on Feb 18 , 19 59 , and that death occurred at 6 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown, Md. DATE SIGNED 2/23/59
ACTUAL SIGNATURE Philip J. Hirshman
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 25-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. View Cemetery | | 22d. LOCATION (City, town, or county) (State)
Sharpsburg Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Albert L. Leaf Wilkomirsky, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 25 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur J. Bowers | |

CERTIFICATE OF DEATH

1917

| | | | |
|------------------------|--|---------------|--|
| Name of Deceased | | John A. Smith | |
| Age | | 45 years | |
| Sex | | Male | |
| Date of Birth | | Sept. 28 1871 | |
| Place of Birth | | Boston, Mass. | |
| Usual Residence | | Boston, Mass. | |
| Cause of Death | | Heart Disease | |
| Date of Death | | Oct. 15 1917 | |
| Place of Death | | Boston, Mass. | |
| Signature of Physician | | [Signature] | |
| Signature of Registrar | | [Signature] | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2376

CERTIFICATE OF DEATH

Reg. Dist. No. 301

02371

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ANNA First MARGARET Middle GEARY Last | | 4. DATE OF DEATH
Month February Day 21 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 6, 1882 |
| 9. AGE (In years last birthday)
76 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Hagerstown, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Christopher G. Boryer | | 14. MOTHER'S MAIDEN NAME
Margaret Garmen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mrs. Margaret Stoner Hagerstown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Leukemia - myeloid - chronic
204.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
2 yrs 2 mo. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 1957 , to Feb. 21, 1959 , that I last saw the deceased alive on Feb. 21, 1959 , and that death occurred at 8:40 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown, Md. DATE SIGNED 2/23/59 | | | |
| ACTUAL SIGNATURE Clayd A. Hoffman M.D. | | PHYSICIAN'S NAME (Type) Clayd A. Hoffman Hagerstown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/24/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Suter-Rouzer Funeral Home
Hagerstown, Md. | | 24a. REC'D BY REGISTRAR
FEB 25 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Clayton S. Kline | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

102

Registration District: North County: Essex

Decedent's Name: John Age: 65 Sex: Male

Residence: 123 North St., Boston, Mass.

Date of Death: October 1, 1952 Time: 10:00 AM

Place of Death: Home

Cause of Death: Heart Disease

Immediate Cause: Myocardial Infarction

Underlying Cause: Coronary Artery Disease

Contributing Cause: None

Medical History: None

Occupation: None

Usual Habits: None

Previous Illnesses: None

Family History: None

Signatures: None

Witnesses: None

Registrar: None

Physician: None

Coroner: None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2377

CERTIFICATE OF DEATH

Reg. Dist. No. 302

02372

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
2 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
830 Potomac Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CLINTON FISK GIBBONS | | 4. DATE OF DEATH February 28 19 59 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 8, 1890 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 11. BIRTHPLACE (State or foreign country)
Poconoke City, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Noah Gibbons | | 14. MOTHER'S MAIDEN NAME
Mary ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I | | 16. SOCIAL SECURITY NO. 705-10-6810 | |
| 17. INFORMANT Mrs. Gertrude Gibbons | | Address Hagerstown, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Dis.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous myocardial infarction. | | INTERVAL BETWEEN ONSET AND DEATH
1 hr.
years. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on never seen alive and that death occurred on 8:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Richard T. Binford | | DATE SIGNED 11 35 Potomac Ave 1 Mar 59 | |
| PHYSICIAN'S NAME (Type) Richard T. Binford | | Hagerstown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/3/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home | | ADDRESS Hagerstown, Md. | |
| 24a. REC'D BY REGISTRAR DATE MAR 5 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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Figure 1. *Staphylococcus aureus* strains used in this study.

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2378

CERTIFICATE OF DEATH

02373

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|------------------------------------|--|--|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75 x -3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u> | | | | d. STREET ADDRESS <u>115 N. Allison St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Karl</u> Middle <u>M.</u> Last <u>Glaser</u> | | | | 4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/19/1896</u> | 9. AGE (In years last birthday) <u>62</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Rural Mail Carrier</u> | | 11. BIRTH PLACE (State or foreign country) <u>Franklin Co. Penna</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles B. Glaser</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura Brindle</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>Mrs. Rhoda B. Glaser</u> | | | | Address <u>Greencastle, Pa.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary arteriosclerosis with thrombosis and resultant myocardial infarction.</u>
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>6 hours.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/1/1939</u> to <u>2/2/1959</u> , that I last saw the deceased alive on <u>2/2/59</u> , and that death occurred at <u>5:40 A. M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Greencastle, Penna.</u> DATE SIGNED <u>2/3/59</u> | | | | | | | |
| ACTUAL SIGNATURE <u>W. C. Brewer</u> | | | | M.D. <u>359 E. Baltimore St., Greencastle, Penna.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. C. Brewer, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2/5/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Pedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co. Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley B. Zimmerman</u> | | | | ADDRESS <u>Greencastle, Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>FEB 5 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MDARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2379

CERTIFICATE OF DEATH

Reg. Dist. No.

02374

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
54 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Martin Manor Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Singleton First Tillberry Middle Grandstaff Last | | | | 4. DATE OF DEATH February Month 11 Day 19 Year 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Mar. 23, 1878 | |
| 9. AGE (In years birthday) 80 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Furniture | | 11. BIRTHPLACE (State or foreign country)
Near Luray Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
Singleton T. Grandstaff | | | | 14. MOTHER'S MAIDEN NAME
Laura Carpenter | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
215-18-1996 | | 17. INFORMANT Address
Mrs. Birtie D. Grandstaff Hagerstown Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331x DUE TO Cerebral hemorrhage
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO Hypertension & arteriosclerosis
(c) year | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had T4R yf 20/11/58 12/27/58 | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 22 Dec , 19 58 , to 11 Feb , 19 59 , that I last saw the deceased alive on 10 Feb , 19 59 , and that death occurred at 5:25 PM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Eldon G. Hoachlander M.D. | | | | DATE SIGNED 115 W. Washington St. | | | |
| PHYSICIAN'S NAME (Type) Eldon G. Hoachlander | | | | Hagerstown Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-13-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Beahm Chapel Cemetery | | 22d. LOCATION (City, town, or county) (State)
Near Luray Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Scott F. Minnich & Son | | | | ADDRESS
Hagerstown Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 13 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2422 CERTIFICATE OF DEATH

Reg. Dist. No.

02375

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sandy Hook | | | | c. LENGTH OF STAY IN 1b
45 yrs/ | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sandy Hook | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Residence | | | | d. STREET ADDRESS
Main Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
JOHN WILLIAM GREENWALT | | | | 4. DATE OF DEATH
Month Day Year
Feb. 23, 1959 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 26, 1902 | |
| 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Trackman (Ret.) | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (State or foreign country)
Loudoun County, Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Abraham Greenwalt | | | | 14. MOTHER'S MAIDEN NAME
Mary Magdaline Mirley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)
WW II 705-05-9522 | | 17. INFORMANT
Mrs. Mazie Hackley
RFD#1, Knoxville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
15 S. MARYLAND AVE | | | | 20g. (County)
BRUNSWICK MD | | 20h. (State)
2-25-19 | |
| 21. I certify that I attended the deceased from 8-23 , 19 59 , to 2-23 , 19 59 , that I last saw the deceased alive on 2-23 , 19 59 , and that death occurred at 12:15 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
15 S. MARYLAND AVE BRUNSWICK MD 2-25-19 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
2/26/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Ebenezer Cemetery | |
| 22d. LOCATION (City, town, or county)
Loudoun County, Virginia | | | | 22e. (State)
VA | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Donald Eckle | | | | ADDRESS
Harpers Ferry, W. Va. | | 24a. REC'D BY REGISTRAR
DATE
FEB 27 1959 | |
| 24b. REGISTRAR'S SIGNATURE
John E. K... | | | | | | | |

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2380

CERTIFICATE OF DEATH

Reg. Dist. No.

02376

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Washington
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
o. STATE Maryland
b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | c. LENGTH OF STAY IN 1b
45 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
03 Hagerstown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Washington County Hospital | | d. STREET ADDRESS
143 West Side Ave. | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) Aaron Newton Grimm Sr. | | 4. DATE OF DEATH
Month February Day 19 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 3, 1893
9. AGE (In years last birthday) 66 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sheet Metal Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Aircraft | 11. BIRTHPLACE (State or foreign country)
Bakerton W. Va. |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Thomas Grimm | |
| 14. MOTHER'S MAIDEN NAME
Margaret Fowlby | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) Yes
(If yes, give war or dates of service) W. W. I | |
| 16. SOCIAL SECURITY NO.
217-07-0680 | | 17. INFORMANT
Mrs. Mary E. Grimm
Address Hagerstown Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion & Myocardial infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis
DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
5 hours
1/20 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus; Had coronary occlusion 10 yrs. ago | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. ft. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1 Nov , 19 50 , to 18 Feb , 19 59 , that I last saw the deceased alive on 18 Feb , 19 59 , and that death occurred at 1:00 P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 115 W. Washington St.
DATE SIGNED _____
ACTUAL SIGNATURE Eldon G. Hoachlander M.D.
PHYSICIAN'S NAME (Type) Eldon G. Hoachlander Hagerstown Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
2-23-59 | 22c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Scott F. Minnich & Son
ADDRESS Hagerstown Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 24 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Harris |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2381

CERTIFICATE OF DEATH

Reg. Dist. No.

02377

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
1 yr. 2 mo. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Garlock Memorial Hospital | | d. STREET ADDRESS
106 E. Salisbury Street | |
| 3. NAME OF DECEASED (Type or print)
First Jacob Middle Henry Last Gruber | | 4. DATE OF DEATH
Month Feb. Day 26 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 4 1870 |
| 9. AGE (In years last birthday)
89 yrs. | | IF UNDER 1 YEAR
Months 1 Days 21 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY
Grocery Store | |
| 11. BIRTHPLACE (State or foreign country)
Williamsport Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel Gruber | | 14. MOTHER'S MAIDEN NAME
Catherine Brubaker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213 24 9910 | |
| 17. INFORMANT
Mr. Vernon Gruber | | Address
4 S. Conococheague St. Williamsport Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
1 Day | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/25/59 to 2/26/59 , that I last saw the deceased alive on 2/26/59 , and that death occurred at 10:27 AM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Williamsport Md DATE SIGNED 2/27/59
ACTUAL SIGNATURE Ralph F. Young M.D. Will: Aug 1st
PHYSICIAN'S NAME (Type) Ralph F. Young | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 28-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Riverview Cemetery | | 22d. LOCATION (City, town, or county) (State)
Williamsport Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Alberta Leaf Williamsport Md | | 24a. REC'D BY REGISTRAR
DATE MAR 2 '59 | |
| 24b. REGISTRAR'S SIGNATURE
C. L. K. K. | | | |

CERTIFICATE OF DEATH

1931

REG. NO. 10

DATE OF DEATH

1931

NAME OF DECEASED

John Doe

AGE

100

SEX

MALE

DATE OF BIRTH

1831

PLACE OF BIRTH

NEW YORK

DATE OF DEATH

1931

CAUSE OF DEATH

HEART DISEASE

PLACE OF DEATH

AT HOME

NO

NO

DATE OF DEATH

1931

NAME OF DECEASED

John Doe

DATE OF BIRTH

1831

PLACE OF BIRTH

NEW YORK

DATE OF DEATH

1931

CAUSE OF DEATH

HEART DISEASE

PLACE OF DEATH

AT HOME

DATE OF DEATH

1931

DATE OF DEATH

1931

NAME OF DECEASED

John Doe

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2382 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02378

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown
c. LENGTH OF STAY IN 1b
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
× Cavetown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
IN Automobile -1600 Blk Jefferson Blvd | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Edgar First M Mahlon Middle Harrison Last | | 4. DATE OF DEATH
Month Feb. Day 16 Year 1959 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 10, 1893 |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months 65 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
welder & machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
machine shop | |
| 11. BIRTHPLACE (State or foreign country)
Hagerstown, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Mahlon Harrison | | 14. MOTHER'S MAIDEN NAME
Susan L. Bett | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
214-09-2328 | |
| 17. INFORMANT
Mrs. Harry Harrison, Rd 3, Hag., Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic
420.1 DUE TO myocardial heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute coronary thrombosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour None o. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
2-17-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
2-19-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Scott F. Minnich & Son, Hagerstown, Md. | | ADDRESS
DATE FEB 19 '59 | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION

2

[illegible]

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

95-0131 **Indole**

Robert F. Minnich & Son, Incorporated, Inc.

2383
CERTIFICATE OF DEATH

Reg. Dist. No.

02379

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, near Lettersburg | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md State Hospital | | | | d. STREET ADDRESS Hagerstown #5 | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Cyrus CLEVELAND HARTLE | | | | 4. DATE OF DEATH Feb. 7 19 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8/25/1884 | |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, R.R. Employee Western Maryland | | | | 11. BIRTHPLACE (State or foreign country) Lettersburg #5 | | | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Fred Hartle | | | | 14. MOTHER'S MAIDEN NAME Mary E. Hemphill | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Mrs. Ida Kriner, Waynesboro Pa. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA LEFT LUNG WITH METASTASIS TO BONE AND LIVER 3 MONTHS
181.0 DUE TO (a) CONFLUENT LOBULAR PNEUMONIA-BACTERIAL 1 WEEK
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA OF BLADDER 11 MONTHS
(c) CARCINOMA OF BLADDER
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease 3 MONTHS PLUS
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from JAN. 14, 19 59, to FEB. 7, 19 59, that I last saw the deceased alive on FEB. 7, 19 59, and that death occurred at 7:15 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Evaristo R. Lardizabal M.D. | | | | ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE DATE SIGNED 2-7-59 | | | |
| PHYSICIAN'S NAME (Type) Evaristo R. Lardizabal | | | | HAGERSTOWN, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/10/59 | | 22c. NAME OF CEMETERY OR CREMATORY Lettersburg | | 22d. LOCATION (City, town, or county) (State) Lettersburg, Washington Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter J. Groves, Waynesboro Pa | | | | 24a. REC'D BY REGISTRAR DATE FEB 10 59 | | 24b. REGISTRAR'S SIGNATURE Arthur E. Adams | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARIAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

2384

02380

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Penna. b. COUNTY Franklin | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
3 weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Ernest O. Hess | | 4. DATE OF DEATH
Month 2 Day 8 Year 1959 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/9/1895 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machenist | | 10b. KIND OF BUSINESS OR INDUSTRY
Landis Machine Co. | 9. AGE (In years last birthday) yrs. 63 |
| 11. BIRTHPLACE (State or foreign country)
Martinsburg, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Hess | | 14. MOTHER'S MAIDEN NAME
Annie Johnson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
173-03-3875 | |
| 17. INFORMANT
Mrs. Ernest O. Hess | | Address
156 Ridge Ave. Waynesboro Penna. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
332x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive thrombosis (cerebral)
DUE TO (c) Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH
few minutes
4 wks. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1/16 , 19 59 , to 2/8 , 19 59 , that I last saw the deceased alive on 2/8 , 19 59 , and that death occurred at 8:35 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 132 N. Potomac Street DATE SIGNED 2/9/59 | | | |
| ACTUAL SIGNATURE A. F. Abdullah M.D. | | PHYSICIAN'S NAME (Type) A. F. Abdullah, M. D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/12/1959 | 22c. NAME OF CEMETERY OR CREMATORY
Green Hill |
| 22d. LOCATION (City, town, or county)
Waynesboro, Pa. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Walter Y. Grove | | ADDRESS
Waynesboro Pa. | |
| 24a. REC'D BY REGISTRAR
DATE FEB 13 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2385

CERTIFICATE OF DEATH

Reg. Dist. No.

02381

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
30 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Washington County Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Michael First Horvath Last | | | | 4. DATE OF DEATH February Month 19 Day 1959 Year | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 2, 1887 | |
| 9. AGE (In years last birthday) 71 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mill Operator | | 11. BIRTHPLACE (State or foreign country)
Hungary | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Istvan Horvath | | | | 14. MOTHER'S MAIDEN NAME
Julia Varga | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
----- | | 16. SOCIAL SECURITY NO.
213-10-6767 | | 17. INFORMANT Address
Miss Ilona Racz Tronto Canada | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 260x Hypertensive Cardiovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis
DUE TO (c) Diabetes mellitus. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs.
17 yrs.
17 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 26 , 19 58 , to Feb 19 , 19 59 , that I last saw the deceased alive on Feb 19 , 19 59 , and that death occurred at 7 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Phillip J. Hirshman M.D. | | | | ADDRESS (Street, city or town, state) 159 W. Washington St. Hagerstown Md. DATE SIGNED 2/20/59 | | | |
| PHYSICIAN'S NAME (Type) Phillip J. Hirshman | | | | Hagerstown Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-21-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Scott F. Minnich & Son | | | | ADDRESS
Hagerstown Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 24 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Prange | | | | | | | |

ARIZONA STATE DEPARTMENT OF HEALTH - TALLAHASSEE 18

2386

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
34 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
613 Sunset Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Catherine Middle Loretta Last Humelsine | | 4. DATE OF DEATH
Month February Day 26 Year 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 20, 1878 |
| 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Mooreville, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John A. Moore | | 14. MOTHER'S MAIDEN NAME
Margaret J. Martin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT
Miss. Mary T. Humelsine | | Address
Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
15 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 15 , 19 57 , to Feb 26 , 19 59 , that I last saw the deceased alive on Feb 25 , 19 59 , and that death occurred at 4:30 A. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Robert P. Conrad M.D. | | ADDRESS (Street, city or town, state) 137 W. Washington DATE SIGNED 2-22-59 | |
| PHYSICIAN'S NAME (Type) Robert P. Conrad | | Hagerstown, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/28/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Suter - Rouzer Funeral Home
R. Franklin Rouzer | | 24a. REC'D BY REGISTRAR
MAR 2 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

216

Worcester

Worcester

Worcester

Worcester

Worcester

Worcester

Worcester

Worcester

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02383

2423

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sharpsburg Md RFD #1 | | | c. LENGTH OF STAY IN 1b
8 yrs. | | | X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sharpsburg Md RFD #1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Antietam | | | | d. STREET ADDRESS
Antietam | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Luther Last Jamison Jr. | | | | 4. DATE OF DEATH
Month Feb. Day 12 Year 1959 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 24 1950 | |
| | | | | 9. AGE (In years last birthday)
8 yrs. | | IF UNDER 1 YEAR
Months 7 Days 18 | |
| | | | | | | IF UNDER 24 HRS.
Hours 18 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Public School | | 11. BIRTHPLACE (State or foreign country)
Hagerstown Md. | |
| | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | | |
| 13. FATHER'S NAME
John Luther Jamison Sr. | | | | 14. MOTHER'S MAIDEN NAME
Altha Mae Crampton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
No | | 17. INFORMANT
John Luther Jamison Sr. Address Antietam Sharpsburg Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute bronchial pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Measles - Dec. 1958; Bronchial asthma | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. none 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE S. Robert Wells M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 15-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. View Cemetery | | 22d. LOCATION (City, town, or county) (State)
Sharpsburg Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Albert Leaf Williams ADDRESS Antietam Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 17 '59 | | 24b. REGISTRAR'S SIGNATURE
Erving S. Kead | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| NAME OF DECEASED
JAMES J. JAMESON | | SEX
Male | | AGE
8 yrs. | | DATE OF DEATH
Jan. 12, 1922 | |
| PLACE OF DEATH
Boston | | STREET
Jackson St. | | CITY
Boston | | COUNTY
Suffolk | |
| OCCUPATION
None | | PLACE OF BIRTH
Ireland | | DATE OF BIRTH
June 24, 1913 | | TIME OF DEATH
7:15 P.M. | |
| NAME OF PHYSICIAN
John Jameson, M.D. | | NAME OF HOSPITAL
None | | NAME OF NURSE
None | | NAME OF ATTENDING PHYSICIAN
John Jameson, M.D. | |
| CAUSE OF DEATH
(To be filled in by the physician) | | MANNER OF DEATH
(To be filled in by the physician) | | PLACE OF INTERMENT
(To be filled in by the physician) | | NAME OF CEMETERY
(To be filled in by the physician) | |
| SIGNATURE OF PHYSICIAN
John Jameson, M.D. | | SIGNATURE OF MEDICAL EXAMINER
(To be filled in by the Medical Examiner) | | SIGNATURE OF NURSE
(To be filled in by the Nurse) | | SIGNATURE OF ATTENDING PHYSICIAN
John Jameson, M.D. | |
| DATE OF SIGNATURE
Jan. 12, 1922 | | DATE OF SIGNATURE
(To be filled in by the Medical Examiner) | | DATE OF SIGNATURE
(To be filled in by the Nurse) | | DATE OF SIGNATURE
Jan. 12, 1922 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15MR
SM 2/57

Items 18-21 Filed 2-10-59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02384

| | | | | | |
|--|---------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
03 Hagerstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Co. Hospital | | | d. STREET ADDRESS
Hamilton Hotel- W. Washington St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
John Ross Jensen | | | 4. DATE OF DEATH
Month Day Year
2 7 19 59 | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 4, 1903 | | 9. AGE (In years last birthday)
55 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY
Hotel Hamilton | | 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
Carl John Jensen | | | 14. MOTHER'S MAIDEN NAME
Maria Hendrickson | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
577-01-5836 | | 17. INFORMANT
Mrs. Audrey Jensen | |
| | | | | Address
Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 871.9 <u>Undetermined - pending autopsy report</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute barbiturate poisoning
DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Undetermined yet</u> none | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. ??None 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
-- | |
| | | | | 20f. (City or town) (County) (State)
-- | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
2-9-59 | |
| EXAMINER'S NAME (Type)
S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
2-10-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Fred W. Kraiss | | ADDRESS
Hagerstown, Md. | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md, | |
| | | 24a. REC'D BY REGISTRAR
DATE FEB 13 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Krauss | |

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW STATE
HEALTH DEPT.

| | | | | | |
|---------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF MINISTER | | 17. SIGNATURE OF CLERGY | | 18. SIGNATURE OF OTHER | |
| 19. SIGNATURE OF OTHER | | 20. SIGNATURE OF OTHER | | 21. SIGNATURE OF OTHER | |
| 22. SIGNATURE OF OTHER | | 23. SIGNATURE OF OTHER | | 24. SIGNATURE OF OTHER | |
| 25. SIGNATURE OF OTHER | | 26. SIGNATURE OF OTHER | | 27. SIGNATURE OF OTHER | |
| 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF OTHER | | 30. SIGNATURE OF OTHER | |
| 31. SIGNATURE OF OTHER | | 32. SIGNATURE OF OTHER | | 33. SIGNATURE OF OTHER | |
| 34. SIGNATURE OF OTHER | | 35. SIGNATURE OF OTHER | | 36. SIGNATURE OF OTHER | |
| 37. SIGNATURE OF OTHER | | 38. SIGNATURE OF OTHER | | 39. SIGNATURE OF OTHER | |
| 40. SIGNATURE OF OTHER | | 41. SIGNATURE OF OTHER | | 42. SIGNATURE OF OTHER | |
| 43. SIGNATURE OF OTHER | | 44. SIGNATURE OF OTHER | | 45. SIGNATURE OF OTHER | |
| 46. SIGNATURE OF OTHER | | 47. SIGNATURE OF OTHER | | 48. SIGNATURE OF OTHER | |
| 49. SIGNATURE OF OTHER | | 50. SIGNATURE OF OTHER | | 51. SIGNATURE OF OTHER | |
| 52. SIGNATURE OF OTHER | | 53. SIGNATURE OF OTHER | | 54. SIGNATURE OF OTHER | |
| 55. SIGNATURE OF OTHER | | 56. SIGNATURE OF OTHER | | 57. SIGNATURE OF OTHER | |
| 58. SIGNATURE OF OTHER | | 59. SIGNATURE OF OTHER | | 60. SIGNATURE OF OTHER | |
| 61. SIGNATURE OF OTHER | | 62. SIGNATURE OF OTHER | | 63. SIGNATURE OF OTHER | |
| 64. SIGNATURE OF OTHER | | 65. SIGNATURE OF OTHER | | 66. SIGNATURE OF OTHER | |
| 67. SIGNATURE OF OTHER | | 68. SIGNATURE OF OTHER | | 69. SIGNATURE OF OTHER | |
| 70. SIGNATURE OF OTHER | | 71. SIGNATURE OF OTHER | | 72. SIGNATURE OF OTHER | |
| 73. SIGNATURE OF OTHER | | 74. SIGNATURE OF OTHER | | 75. SIGNATURE OF OTHER | |
| 76. SIGNATURE OF OTHER | | 77. SIGNATURE OF OTHER | | 78. SIGNATURE OF OTHER | |
| 79. SIGNATURE OF OTHER | | 80. SIGNATURE OF OTHER | | 81. SIGNATURE OF OTHER | |
| 82. SIGNATURE OF OTHER | | 83. SIGNATURE OF OTHER | | 84. SIGNATURE OF OTHER | |
| 85. SIGNATURE OF OTHER | | 86. SIGNATURE OF OTHER | | 87. SIGNATURE OF OTHER | |
| 88. SIGNATURE OF OTHER | | 89. SIGNATURE OF OTHER | | 90. SIGNATURE OF OTHER | |
| 91. SIGNATURE OF OTHER | | 92. SIGNATURE OF OTHER | | 93. SIGNATURE OF OTHER | |
| 94. SIGNATURE OF OTHER | | 95. SIGNATURE OF OTHER | | 96. SIGNATURE OF OTHER | |
| 97. SIGNATURE OF OTHER | | 98. SIGNATURE OF OTHER | | 99. SIGNATURE OF OTHER | |
| 100. SIGNATURE OF OTHER | | 101. SIGNATURE OF OTHER | | 102. SIGNATURE OF OTHER | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT

1
2388

Wells
181

1

0

21

2

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02385

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN
c. LENGTH OF STAY IN 1b
14 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON COUNTY HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
03 HAGERSTOWN
d. STREET ADDRESS
315 FREDERICK STREET
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
JOHN T. KEPHART | | 4. DATE OF DEATH
Month
FEBRUARY
Day
26
Year
1959 19 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 26 1896 |
| 9. AGE (In years last birthday)
62 yrs. | | 10. IF UNDER 1 YEAR
Months
03
Days
00
Hours
00
Min.
00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MAINTENANCE DEPT. FAIRCHILD AIRCRAFT MYERSVILLE FRED.CO.MD.U.S.A. | | 10b. KIND OF BUSINESS OR INDUSTRY
MAINTENANCE DEPT. FAIRCHILD AIRCRAFT MYERSVILLE FRED.CO.MD.U.S.A. | |
| 11. BIRTHPLACE (State or foreign country)
MAINTENANCE DEPT. FAIRCHILD AIRCRAFT MYERSVILLE FRED.CO.MD.U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
MAINTENANCE DEPT. FAIRCHILD AIRCRAFT MYERSVILLE FRED.CO.MD.U.S.A. | |
| 13. FATHER'S NAME
NO RECORD | | 14. MOTHER'S MAIDEN NAME
ALMA ALEXANDER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
224 20 7150 | |
| 17. INFORMANT
MRS. ROOSEVELT GILARDI BOONSBORO MD. | | Address
MRS. ROOSEVELT GILARDI BOONSBORO MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple fracture of ribs and sternum
823X DUE TO
Open fracture left patella
Conditions, if any, which gave rise to immediate cause (b) Acute ventricular fibrillation
(a), stating the underlying cause last. DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
16 hrs
16 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
None | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of car that hit a tree when car failed to negotiate a curve | |
| 20c. TIME OF INJURY
Month, Day, Year
6:15
Hour
6:15
p. m.
Feb. 25 1959 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Highway | | 20f. (City or town)
Rural-Smbg, Wash
(County)
MD
(State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED
2-27-59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
MARCH 1 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
LUTHERAN CEMETERY | | 22d. LOCATION (City, town, or county)
MIDDLETOWN FRED.CO.MD.
(State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John H. Bast | | ADDRESS
Boonsboro Md | |
| 24a. REC'D BY REGISTRAR
MAR 2 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2424

CERTIFICATE OF DEATH

Reg. Dist. No.

02386

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
COUNTY
Washington
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE
Maryland COUNTY
Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Boonsboro | | c. LENGTH OF STAY IN 1b
3 Yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Fahrney- Keedy Home | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
LILLIE VELONA KIRACOFE | | 4. DATE OF DEATH
Month Day Year
February 5 1959 19 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 19 1870 |
| 9. AGE (In years last birthday) yrs.
88 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Downsville Fred Co Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
David Stroh | | 14. MOTHER'S MAIDEN NAME
Elizabeth Landis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mrs Pauline Snyder Walkersville | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
10 yrs. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 2, 1958 , to Feb 5, 1959 , that I last saw the deceased alive on Feb. 4, 1959 , and that death occurred at 11 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
G. W. Williams | | ADDRESS (Street, city or town, state)
Boonsboro | |
| PHYSICIAN'S NAME (Type)
G. W. Williams | | DATE SIGNED
2/6/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/8/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
River View Cemetery | | 22d. LOCATION (City, town, or county) (State)
Williamsport Wash. Co Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Andrew K. Coffman | | ADDRESS
Hagerstown Md. | |
| 24a. REC'D BY REGISTRAR
FEB 9 59 | | 24b. REGISTRAR'S SIGNATURE
Ind. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1919

Form No. 1

| | | | |
|----------------------------------|--|------------------------------------|--|
| <p>1. Name of deceased</p> | | <p>2. Sex</p> | |
| <p>3. Age</p> | | <p>4. Date of birth</p> | |
| <p>5. Place of birth</p> | | <p>6. Date of death</p> | |
| <p>7. Cause of death</p> | | <p>8. Place of death</p> | |
| <p>9. Signature of physician</p> | | <p>10. Signature of registrar</p> | |
| <p>11. Date of registration</p> | | <p>12. Signature of registrar</p> | |
| <p>13. Date of registration</p> | | <p>14. Signature of registrar</p> | |
| <p>15. Date of registration</p> | | <p>16. Signature of registrar</p> | |
| <p>17. Date of registration</p> | | <p>18. Signature of registrar</p> | |
| <p>19. Date of registration</p> | | <p>20. Signature of registrar</p> | |
| <p>21. Date of registration</p> | | <p>22. Signature of registrar</p> | |
| <p>23. Date of registration</p> | | <p>24. Signature of registrar</p> | |
| <p>25. Date of registration</p> | | <p>26. Signature of registrar</p> | |
| <p>27. Date of registration</p> | | <p>28. Signature of registrar</p> | |
| <p>29. Date of registration</p> | | <p>30. Signature of registrar</p> | |
| <p>31. Date of registration</p> | | <p>32. Signature of registrar</p> | |
| <p>33. Date of registration</p> | | <p>34. Signature of registrar</p> | |
| <p>35. Date of registration</p> | | <p>36. Signature of registrar</p> | |
| <p>37. Date of registration</p> | | <p>38. Signature of registrar</p> | |
| <p>39. Date of registration</p> | | <p>40. Signature of registrar</p> | |
| <p>41. Date of registration</p> | | <p>42. Signature of registrar</p> | |
| <p>43. Date of registration</p> | | <p>44. Signature of registrar</p> | |
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| <p>55. Date of registration</p> | | <p>56. Signature of registrar</p> | |
| <p>57. Date of registration</p> | | <p>58. Signature of registrar</p> | |
| <p>59. Date of registration</p> | | <p>60. Signature of registrar</p> | |
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| <p>71. Date of registration</p> | | <p>72. Signature of registrar</p> | |
| <p>73. Date of registration</p> | | <p>74. Signature of registrar</p> | |
| <p>75. Date of registration</p> | | <p>76. Signature of registrar</p> | |
| <p>77. Date of registration</p> | | <p>78. Signature of registrar</p> | |
| <p>79. Date of registration</p> | | <p>80. Signature of registrar</p> | |
| <p>81. Date of registration</p> | | <p>82. Signature of registrar</p> | |
| <p>83. Date of registration</p> | | <p>84. Signature of registrar</p> | |
| <p>85. Date of registration</p> | | <p>86. Signature of registrar</p> | |
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| <p>89. Date of registration</p> | | <p>90. Signature of registrar</p> | |
| <p>91. Date of registration</p> | | <p>92. Signature of registrar</p> | |
| <p>93. Date of registration</p> | | <p>94. Signature of registrar</p> | |
| <p>95. Date of registration</p> | | <p>96. Signature of registrar</p> | |
| <p>97. Date of registration</p> | | <p>98. Signature of registrar</p> | |
| <p>99. Date of registration</p> | | <p>100. Signature of registrar</p> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02387

2425

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown R # 2
c. LENGTH OF STAY IN 1b
25 Yrs | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Hagerstown R # 2
d. STREET ADDRESS
Western Pike
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
BERT EUGENE KITZMILLER | | 4. DATE OF DEATH
Month February Day 3 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 16 1884 |
| 9. AGE (In years last birthday)
74 yrs. | | 10. BIRTHPLACE (State or foreign country)
Hagerstown Wash. Co Md. | |
| 11. CITIZEN OF WHAT COUNTRY?
USA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Enos Kitzmiller | | 14. MOTHER'S MAIDEN NAME
Clara Hammersla | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
----- | |
| 17. INFORMANT
Mrs Corinne R. Kitzmiller | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Pancreas
157X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hagerstown Md. R # 2
INTERVAL BETWEEN ONSET AND DEATH
2 months | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 3, 1958 to Feb. 3, 1959 that I lost s/he the deceased alive on Feb. 2, 1959 , and that death occurred at 7:15 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
David R. Brewer | | ADDRESS (Street, city or town, state)
Clear Spring Md | |
| PHYSICIAN'S NAME (Type)
David R. Brewer | | DATE SIGNED
2/6/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/6/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St Pauls Cemetery near Clear Spring Wash. | | 22d. LOCATION (City, town, or county) (State)
Con Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Andrew K. Coffman Hagerstown Md. | | 24a. REC'D BY REGISTRAR
FEB 9 '59 | |
| 24b. REGISTRAR'S SIGNATURE
C. H. S. H. H. | | | |

2388

CERTIFICATE OF DEATH

Reg. Dist. No.

02388

| | | | |
|--|------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown Md | | c. LENGTH OF STAY IN lb
3 Wks. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Harry Bertum Lashley | | 4. DATE OF DEATH
Month Day Year
2 22 19 59 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 24, 1895 |
| 9. AGE (In years last birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
4 28 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farming | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | |
| 11. BIRTHPLACE (State or foreign country)
Fulton County Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles E Lashley | | 14. MOTHER'S MAIDEN NAME
Rebecca J Nycum | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
James E Lashley Penna. Ave. Hancock Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gas Gangrene Left Leg
450.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Asterio Sclerotic Peripheral Vascular Disease
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7 Feb , 19 59 , to 22 Feb , 19 59 , that I last saw the deceased alive on 21 Feb , 19 59 , and that death occurred at 9 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Frank E Brumback M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED
170 West Washington ST | |
| PHYSICIAN'S NAME (Type)
Frank E Brumback Hagerstown Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2.25.59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rehobeth Methodist | | 22d. LOCATION (City, town, or county) (State)
Fulton County Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Howard J Shove Hancock Md | | 24a. REC'D BY REGISTRAR
FEB 27 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2390

CERTIFICATE OF DEATH

Reg. Dist. No.

02389

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
03 Hagerstown | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Wash. Co. Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle P Last Lawrence | | | | 4. DATE OF DEATH
Month 2 Day 17 Year 19 59 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 31, 1873 | |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY
silk weaver | | 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
unknown | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
217-10-2801 | | 17. INFORMANT
Mrs. Ethel Lorshbaugh Address Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage
DUE TO Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis
DUE TO (c) Cerebral Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from Feb 17, 1959 , to Feb 17, 1959 , that I last saw the deceased alive on Feb 17, 8:30 P. , 19 59 , and that death occurred at 11:59 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John D. Turco MD M.D. | | | | ADDRESS (Street, city or town, state) 302 N. Potomac St | | | |
| PHYSICIAN'S NAME (Type) JOHN D. TURCO MD | | | | DATE SIGNED HAGERSTOWN MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
2-21-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Fred W. Kraiss Address Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 24 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

CERTIFICATE OF DEATH

2390

FILE NO.

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

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PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

2391

CERTIFICATE OF DEATH

Reg. Dist. No.

02390

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HAGERSTOWN</u> | | | | c. LENGTH OF STAY IN TB
<u>TWO DAYS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>WASHINGTON COUNTY HOSPITAL</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>DUANE</u> Middle <u>ERIC</u> Last <u>MARSHALL</u> | | | | 4. DATE OF DEATH
Month <u>FEBRUARY</u> - Day <u>3</u> , 19 <u>59</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>FEBRUARY-1-1959</u> | |
| 9. AGE (In years last birthday)
<u>TWO</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>HAGERSTOWN WASH. CO. MD.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>LUTHER MARSHALL</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>ALICE POOLE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>LUTHER MARSHALL SHARPSBURG MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>760.5 Bilateral atelectasis with hyaline membrane</u> 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral tears of the tentorium cerebelli</u> 2 Days
DUE TO (c) <u>Prematurity -- 1 month, - birth injury.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>birth</u> , 19 <u>59</u> to <u>Feb. 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 2, 1959</u> , and that death occurred at <u>9:30 A</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>Feb. 3, 59</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>FEB. 4. 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>SAMPLES MANOR CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>SAMPLES MANOR WASH. CO. MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John H. Post</u> ADDRESS <u>BOONSBORO MD</u> | | | | 24a. REC'D BY REGISTRAR
<u>FEB 6</u> DATE | | 24b. REGISTRAR'S SIGNATURE
<u>John H. Post</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2281323XV3

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------------|--|---------------------------------------|--|---------------------------------------|--|
| 1. NAME OF DECEASED
[Blank] | | 2. SEX
[Blank] | | 3. AGE
[Blank] | |
| 4. DATE OF DEATH
[Blank] | | 5. TIME OF DEATH
[Blank] | | 6. PLACE OF DEATH
[Blank] | |
| 7. CAUSE OF DEATH
[Blank] | | 8. MANNER OF DEATH
[Blank] | | 9. PLACE OF BIRTH
[Blank] | |
| 10. OCCUPATION
[Blank] | | 11. EDUCATION
[Blank] | | 12. MARITAL STATUS
[Blank] | |
| 13. PREVIOUS ILLNESS
[Blank] | | 14. MEDICAL HISTORY
[Blank] | | 15. SURVIVAL OF SURVIVORS
[Blank] | |
| 16. SIGNATURE OF DECEASED
[Blank] | | 17. SIGNATURE OF WITNESS
[Blank] | | 18. SIGNATURE OF DECEASED
[Blank] | |
| 19. SIGNATURE OF DECEASED
[Blank] | | 20. SIGNATURE OF DECEASED
[Blank] | | 21. SIGNATURE OF DECEASED
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| 22. SIGNATURE OF DECEASED
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| 25. SIGNATURE OF DECEASED
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| 28. SIGNATURE OF DECEASED
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| 31. SIGNATURE OF DECEASED
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| 34. SIGNATURE OF DECEASED
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| 37. SIGNATURE OF DECEASED
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| 40. SIGNATURE OF DECEASED
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| 43. SIGNATURE OF DECEASED
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| 46. SIGNATURE OF DECEASED
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| 49. SIGNATURE OF DECEASED
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| 52. SIGNATURE OF DECEASED
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| 55. SIGNATURE OF DECEASED
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| 58. SIGNATURE OF DECEASED
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| 61. SIGNATURE OF DECEASED
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| 64. SIGNATURE OF DECEASED
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| 67. SIGNATURE OF DECEASED
[Blank] | | 68. SIGNATURE OF DECEASED
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| 70. SIGNATURE OF DECEASED
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| 73. SIGNATURE OF DECEASED
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| 76. SIGNATURE OF DECEASED
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| 79. SIGNATURE OF DECEASED
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| 82. SIGNATURE OF DECEASED
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| 85. SIGNATURE OF DECEASED
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| 88. SIGNATURE OF DECEASED
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| 91. SIGNATURE OF DECEASED
[Blank] | | 92. SIGNATURE OF DECEASED
[Blank] | | 93. SIGNATURE OF DECEASED
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| 94. SIGNATURE OF DECEASED
[Blank] | | 95. SIGNATURE OF DECEASED
[Blank] | | 96. SIGNATURE OF DECEASED
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| 97. SIGNATURE OF DECEASED
[Blank] | | 98. SIGNATURE OF DECEASED
[Blank] | | 99. SIGNATURE OF DECEASED
[Blank] | |
| 100. SIGNATURE OF DECEASED
[Blank] | | 101. SIGNATURE OF DECEASED
[Blank] | | 102. SIGNATURE OF DECEASED
[Blank] | |

3

MASSACHUSETTS DEPARTMENT OF HEALTH - BULLDOZER 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2392 CERTIFICATE OF DEATH

02391

Reg. Dist. No. 302

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
12 Weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Wash County Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First ANNIE Middle MIDDLEKAUFF- Last McBRIDE | | | | 4. DATE OF DEATH
Month February Day 13 Year 1959 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 8 1884 | | 9. AGE (In years last birthday) yrs. 74 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Yarrowsburg Wash. Co Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Lewis P. Kaetzel | | | | 14. MOTHER'S MAIDEN NAME
Laura M. Fouch | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
William F. McBride Address 111 No Locust St | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
522x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema
DUE TO (c) 6-8 mo. | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Arteriosclerotic heart disease, Renal insufficiency | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 23 JUNE , 19 57 , to 13 FEBRUARY 19 59 , that I last saw the deceased alive on 13 FEBRUARY , 19 59 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Richard T. Binford | | | | ADDRESS (Street, city or town, state) 1135 POTOMAC AVENUE | | | |
| PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D. | | | | DATE SIGNED 2/14/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/16/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Wash Co Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Andrew K. Coffman | | | | 24a. REC'D BY REGISTRAR
FEB 17 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kinch | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES J. JONES | | M | | 45 | | JAN 15 1880 | | NEW YORK | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| 123 MAIN ST. BOSTON | | LABORER | | HEART DISEASE | | NATURAL | | HOSPITAL | |
| DATE OF DEATH | | TIME OF DEATH | | HOUR OF DEATH | | MINUTE OF DEATH | | SECOND OF DEATH | |
| JAN 20 1920 | | 10:30 AM | | 10 | | 30 | | 00 | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| J. J. JONES | | J. J. JONES | | J. J. JONES | | J. J. JONES | | J. J. JONES | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| JAN 20 1920 | | JAN 20 1920 | | JAN 20 1920 | | JAN 20 1920 | | JAN 20 1920 | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2426

CERTIFICATE OF DEATH

Reg. Dist. No.

02392

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Wash.</u> Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE W. Va. b. COUNTY Morgan | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hancock | | | | c. LENGTH OF STAY IN 1b
1 Yr. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Hancock Nursing Home | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Largent 85 X-3 | | | |
| | | | | d. STREET ADDRESS
Rural | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First LuLu Middle B. Last McKee | | | | 4. DATE OF DEATH Feb. 14, 19 59 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Mar. 21, 1975 | |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months 10 Days 23 | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
---- | | | |
| 11. BIRTHPLACE (State or foreign country)
Morgan County, W. Va. | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Jacob Hutchinson | | | | 14. MOTHER'S MAIDEN NAME
Margaret Powell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
 | | | |
| 17. INFORMANT
Mrs Irvin Ambrose, Largent, W. Va. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Embolus
153.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of ascending colon
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Unknown | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. n. 19 p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from Jan. 1, 1959 , to Jan. 9, 1959 , that I last saw the deceased alive on Jan. 9, 1959 , and that death occurred at 5:53 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE H. E. Tabler | | | | ADDRESS (Street, city or town, state) Hancock, Md. | | | |
| DATE SIGNED 2/14/59 | | | | | | | |
| PHYSICIAN'S NAME (Type) H. E. Tabler | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/18/1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Enon Ch. Cem. | | 22d. LOCATION (City, town, or county) (State)
Largent, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
PARKS FUNERAL HOME, BERKELEY SPGS, W. VA. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 16 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kenna | |

2393

CERTIFICATE OF DEATH

Reg. Dist. No.

302

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | | c. LENGTH OF STAY IN TB
<u>4 Weeks</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Wash. county Hospital</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. STREET ADDRESS
<u>37 Mealey Parkway</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>WALTER WILLIAM McPHAIL</u> | | | | 4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 6 1907</u> | |
| 9. AGE (In years last birthday)
<u>51</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Merchant</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore City Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>John McPhail</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Clementine Merritt</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>-----</u> | | 17. INFORMANT
<u>Mrs Mary McPhail 37 Mealey Parkway Hagerstown Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure on basis of Hypertensive Atheromatous Cardiovascular Disease.</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u> </u>
(c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>None.</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u> </u> p. m. <u> </u> 19 <u>59</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Aug. 11, 1958</u> to <u>Feb. 5, 1959</u> , that I last saw the deceased alive on <u>Feb. 5, 1959</u> , and that death occurred at <u>5:45 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R.A. Bell</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>119 North Potomac Street, 2-6-59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u> | | | | <u>Hagerstown, Maryland.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/8/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rest Haven Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Hagerstown Wash. Co Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Andrew K. Coffman Hagerstown Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 9 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hines</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

435

2394

CERTIFICATE OF DEATH

Reg. Dist. No.

02394

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b
2 HOURS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
WASHINGTON COUNTY HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
VICTOR MILTON METZ | | | | 4. DATE OF DEATH
Month Day Year
FEBRUARY - 8 19 59 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 27 - 1876 | 9. AGE (In years last birthday)
82 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED FARMER. OWN FARM | | | | 10b. KIND OF BUSINESS OR INDUSTRY
ROHRERSVILLE WASH. Co. MD. U.S.A. | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
JACOB METZ | | | |
| 14. MOTHER'S MAIDEN NAME
JANIE GRIMM | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | |
| 16. SOCIAL SECURITY NO.
NONE | | | | 17. INFORMANT
MRS. WALTER GREEN FAIRPLAY MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
434.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month Day Year
Hour a. m. _____ p. m. _____ 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from Aug 1 , 19 58 , to Feb 8 , 19 59 , that I last saw the deceased alive on Feb 6 , 19 59 , and that death occurred at 7:35 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE M. Byrhit | | | | ADDRESS (Street, city or town, state) 28 W Potomac Wnsgts | | | |
| PHYSICIAN'S NAME (Type) del | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
FEB. 11, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
MANOR CEMETERY | | 22d. LOCATION (City, town, or county) (State)
BOONSBORO MD. ROUTE 1 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John H. East | | | | 24a. REC'D BY REGISTRAR
DATE FEB 11 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5352

| | | | | | | | | | |
|---------------------------------|--|-------------------------------|--|-------------------------------|--|--------------------------------|--|-------------------------------|--|
| NAME OF DECEASED
_____ | | SEX
_____ | | AGE
_____ | | DATE OF BIRTH
_____ | | PLACE OF BIRTH
_____ | |
| OCCUPATION
_____ | | MARITAL STATUS
_____ | | CAUSE OF DEATH
_____ | | MANNER OF DEATH
_____ | | PLACE OF DEATH
_____ | |
| DATE OF DEATH
_____ | | TIME OF DEATH
_____ | | PLACE OF DEATH
_____ | | COUNTY
_____ | | STATE
_____ | |
| SIGNATURE OF PHYSICIAN
_____ | | SIGNATURE OF CORONER
_____ | | SIGNATURE OF JURY
_____ | | SIGNATURE OF DECEASED
_____ | | SIGNATURE OF WITNESS
_____ | |
| CERTIFICATE OF DEATH
_____ | | CERTIFICATE OF DEATH
_____ | | CERTIFICATE OF DEATH
_____ | | CERTIFICATE OF DEATH
_____ | | CERTIFICATE OF DEATH
_____ | |

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 JAN 10 1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02395

2395

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
27 Hrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sh. county Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle CLIFFORD Last MILLER | | | | 4. DATE OF DEATH
Month February Day 25 Year 1959 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct 9 1881 | |
| 9. AGE (In years last birthday)
77 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lumber Dealer | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
Va. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Charles W. Miller | | 14. MOTHER'S MAIDEN NAME
Rose Amelia Branham | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Beaudric C. Miller 607 W. Washington St | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage.
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis.
DUE TO (c) ? | | | | INTERVAL BETWEEN ONSET AND DEATH
29 hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
None. | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 24, 1959 to Feb. 25, 1959 , that I last saw the deceased alive on February 25, 1959 , and that death occurred at 5:00PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<i>R.A. Bell</i> | | | | ADDRESS (Street, city or town, state) DATE SIGNED
119 North Potomac Street, 2-27-59 | | | |
| PHYSICIAN'S NAME (Type)
R.A. Bell, M.D. | | | | Hagerstown, Maryland. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/28/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Wash. Co Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Andrew K. Coffman Hagerstown Md. | | | | 24a. REC'D BY REGISTRAR
DATE MAR 3 '59 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur L. Hanna</i> | |

CERTIFICATE OF DEATH

1912

REG. DIST. NO.

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
MARRIED
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
RELIGION
MARITAL STATUS
SINGLE
MARRIED
WIDOWED
DIVORCED

DATE OF MARRIAGE
PLACE OF MARRIAGE
NAME OF SPOUSE
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
RELIGION
MARITAL STATUS
SINGLE
MARRIED
WIDOWED
DIVORCED

DATE OF MARRIAGE
PLACE OF MARRIAGE
NAME OF SPOUSE
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
RELIGION
MARITAL STATUS
SINGLE
MARRIED
WIDOWED
DIVORCED

DATE OF MARRIAGE
PLACE OF MARRIAGE
NAME OF SPOUSE
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
RELIGION
MARITAL STATUS
SINGLE
MARRIED
WIDOWED
DIVORCED

DATE OF MARRIAGE
PLACE OF MARRIAGE
NAME OF SPOUSE
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
RELIGION
MARITAL STATUS
SINGLE
MARRIED
WIDOWED
DIVORCED

DATE OF MARRIAGE
PLACE OF MARRIAGE
NAME OF SPOUSE
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
RELIGION
MARITAL STATUS
SINGLE
MARRIED
WIDOWED
DIVORCED

DATE OF MARRIAGE
PLACE OF MARRIAGE
NAME OF SPOUSE
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
RELIGION
MARITAL STATUS
SINGLE
MARRIED
WIDOWED
DIVORCED

DATE OF MARRIAGE
PLACE OF MARRIAGE
NAME OF SPOUSE
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

2396

CERTIFICATE OF DEATH

Reg. Dist. No.

02396

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | | c. LENGTH OF STAY IN 1b
<u>Life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>106 Fairground Ave.</u> | | | | d. STREET ADDRESS
<u>106 Fairground Ave.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MATTIE</u> Middle <u>EVA</u> Last <u>MOORE</u> | | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>13</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 2, 1890</u> | | 9. AGE (In years last birthday)
<u>68</u> yrs. | IF UNDER 1 YEAR
Months <u>3</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS.
Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Fulton County, Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Lewis Evan Mills</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Christine Houch</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Mr. H.M. Moore</u> Address <u>106 Fairground Ave. Hagerstown, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uterine</u>
<u>200.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Retroperitoneal Reticulum cell Sarcoma</u>
DUE TO (c) <u>3 months</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 months</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>19</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 27, 1958</u> , to <u>Nov 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 13</u> , 19 <u>59</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>John D. Turco</u> | | | | ADDRESS (Street, city or town, state)
<u>302 W. Potomac St. Hagerstown MD</u> | | | |
| DATE SIGNED
<u>2-13-59</u> | | | | | | | |
| PHYSICIAN'S NAME (Type)
<u>JOHN D. TURCO</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/16/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Paul Church Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>St. Paul Washington Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 17 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. A. Horst O-Proc.

CERTIFICATE OF DEATH

2886

| | | | | | | | |
|-----------------------|--|------------------------|--|-----------------------|--|---------------------|--|
| NAME OF DECEASED | | LAST NAME | | FIRST NAME | | MIDDLE NAME | |
| JAMES H. HARRIS | | HARRIS | | JAMES | | HARRIS | |
| AGE | | SEX | | RACE | | RELIGION | |
| 65 | | Male | | White | | Roman Catholic | |
| DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | |
| 1880 | | Maryland | | Baltimore | | Maryland | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | |
| 1945 | | Maryland | | Baltimore | | Maryland | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | |
| Heart Disease | | Natural | | Teacher | | High School | |
| DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY OF INTERMENT | | STATE OF INTERMENT | |
| 1945 | | Maryland | | Baltimore | | Maryland | |
| NAME OF FUNERAL HOME | | NAME OF MINISTER | | NAME OF CHURCH | | NAME OF CEMETERY | |
| Harris & Sons | | Rev. J. H. Harris | | St. James Church | | St. James Cemetery | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | | SIGNATURE OF MINISTER | | SIGNATURE OF CHURCH | |
| | | | | | | | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| 1945 | | 1945 | | 1945 | | 1945 | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH DEPARTMENT. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW YORK. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF FLORIDA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ALABAMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSISSIPPI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF LOUISIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW MEXICO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IDAHO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MONTANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WYOMING. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF COLORADO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF UTAH. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW MEXICO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IDAHO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MONTANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WYOMING. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF COLORADO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF UTAH.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2427

CERTIFICATE OF DEATH

Reg. Dist. No.

02397

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CLEVELANDVILLE RURAL | | | | c. LENGTH OF STAY IN 1b
50 YEARS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
BOONSBORO MD. ROUTE 2 | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First EZRA Middle JACOB Last MOSER | | | | 4. DATE OF DEATH
Month FEBRUARY Day 14 Year 1959 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
APRIL 1 1877 | |
| 9. AGE (In years last birthday)
81 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED TEACHER | | 11. BIRTHPLACE (State or foreign country)
NEAR MYERSVILLE FRED. CO. MD. U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ABRAHAM MOSER | | | | 14. MOTHER'S MAIDEN NAME
ELIZABETH SCHILDTKNECHT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MRS. CARRIE MOSER BOONSBORO MD. ROUTE 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-vascular - renal disease
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia - caused by above
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
5 Yr (?)
1 week. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 1 , 19 59 , to 2/14/59 , 19 59 , that I last saw the deceased alive on Feb. 13 , 19 59 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Walter H. Shealy M.D. | | | | ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 2/16/59 | | | |
| PHYSICIAN'S NAME (Type) Walter H. Shealy M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
FEB. 17 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
BOONSBORO CEMETERY | | 22d. LOCATION (City, town, or county) (State)
BOONSBORO WASH. CO. MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John H. Bass | | | | 24a. REC'D BY REGISTRAR
DATE FEB 20 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2428
CERTIFICATE OF DEATH

Reg. Dist. No.

02398

| | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sharpsburg
c. LENGTH OF STAY IN 1b 6 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharpsburg R.F.D. #1 | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Sharpsburg (Taylor's Landing)
d. STREET ADDRESS Sharpsburg R. F. D. #1
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Richard H Middle Petters Last Petters | | | | 4. DATE OF DEATH
Month Feb. Day 12 Year 1959 | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb 23, 1905 53 yrs. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Engineer Fort Ritchie Md | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) 53 yrs. | | | | | |
| 11. BIRTHPLACE (State or foreign country) Lancaster Penna | | | | 12. CITIZEN OF WHAT COUNTRY? American | | | | | | | |
| 13. FATHER'S NAME Late Richard H. Petters | | | | 14. MOTHER'S MAIDEN NAME Augusta Fenske | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 2d. W II | | | | 16. SOCIAL SECURITY NO. Ascar Petters 201 Park St | | | | | | | |
| 17. INFORMANT Samuel R | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary Sclerosis
DUE TO
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH
2 hours.
3 yrs. (?) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I attended the deceased from September 1957 to Feb. 12, 1959 , that I last saw the deceased alive on Feb. 9, 1959 , and that death occurred at 9 P. M. from the causes and on the date stated above. | | | | | | | | | | | |
| ACTUAL SIGNATURE Walter H. Shealy | | | | ADDRESS (Street, city or town, state) Feb. 12, 1959 | | | | | | | |
| PHYSICIAN'S NAME (Type) Walter H. Shealy M.D. | | | | DATE SIGNED Feb. 12, 1959 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | 2-16-59 | | Lincolnton Municipal | | Lancaster Penna | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md | | | | 24a. REC'D BY REGISTRAR FEB 16 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John P. Patten 201 May 11
Carpenter Thomas
Patterson
John P. Patten 201 May 11
Carpenter Thomas
Patterson
John P. Patten 201 May 11
Carpenter Thomas
Patterson

John P. Patten 201 May 11
Carpenter Thomas
Patterson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02399

2429

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Sharpsburg Md.</u> | | | | c. LENGTH OF STAY IN 1b
<u>73 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>114 East Main Street</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Allen</u> Middle <u>Luther</u> Last <u>Poffenberger</u> | | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>4</u> Year <u>19 59</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 10 1885</u> | 9. AGE (In years last birthday) yrs. <u>73</u> | IF UNDER 1 YEAR
Months <u>8</u> Days <u>24</u> | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret'd School Principal</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>School</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Sharpsburg Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Otho Poffenberger</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Welsh</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>219 34 5104</u> | | | |
| 17. INFORMANT
<u>Mrs. Dora Poffenberger</u> | | | | Address <u>114 E. Main St. Sharpsburg Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u>
DUE TO
(c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>

<u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Bilateral retinitis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>at death</u> , 19 <u>59</u> , to <u>5.15A</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 4</u> , 19 <u>59</u> , and that death occurred at <u>5.15A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Walter H. Shealy</u> | | | | ADDRESS (Street, city or town, state)
<u>Sharpsburg, Md.</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Walter H. Shealy M. D.</u> | | | | DATE SIGNED
<u>2/5/59.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Feb. 7 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt. View Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Sharpsburg Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Albert L. Wolf Williamsport, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 9 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2397

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | | | c. LENGTH OF STAY IN 1b
<u>1 Month</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
<u>Western Md. State Hospital</u> | | | | d. STREET ADDRESS
<u>603 No Prospect St</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>William</u> Middle <u>Henry</u> Last <u>Powers</u> | | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>15</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>December 12 1881</u> | |
| 9. AGE (In years lost birthday)
<u>77</u> yrs. | | IF UNDER 1 YEAR
Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. | | IF UNDER 24 HRS.
Hours <u>7</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Stone Mason</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self Employed Colinsville Penna</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>USA</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Frank Powers</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Eliza Easton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u> | | | | 16. SOCIAL SECURITY NO.
<u>217-18-8998</u> | | | |
| 17. INFORMANT
<u>Mrs Mae Babb</u> | | | | Address
<u>603 No Prospect St</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Thrombosis of left circumflex artery + left auricle</u>
DUE TO
(c) <u>arteriosclerosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 days</u>
<u>7 days</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>cerebral thrombosis</u> | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month <u>19</u> Day <u>19</u> Year <u>1959</u>
Hour a. m. <u>19</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>January 15, 1959</u> to <u>February 15, 1959</u> , that I last saw the deceased alive on <u>February 15, 1959</u> , and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Victor L. Ramos</u> | | | | ADDRESS (Street, city or town, state)
<u>Western Md. State Hospital</u> | | | |
| DATE SIGNED
<u>Feb. 15, 1959</u> | | | | | | | |
| PHYSICIAN'S NAME (Type)
<u>Victor L. Ramos</u> | | | | <u>Hagerstown, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/18/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Brethren Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Brownsville Wash. Co Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Andrew K. Coffman</u> | | | | ADDRESS
<u>Hagerstown Md.</u> | | | |
| 24a. REC'D BY REGISTRAR
<u>Feb 17 '59</u> | | | | 24b. REGISTRAR'S SIGNATURE
<u>John E. K...</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2287

| | | | | | |
|--|--|--|--|---|--|
| NAME OF DECEASED
MARY ELIZABETH | | SEX
F | | AGE
72 | |
| DATE OF DEATH
JAN 10 1900 | | PLACE OF DEATH
HOME | | CITY
BOSTON | |
| TIME OF DEATH
10:30 AM | | CAUSE OF DEATH
OLD AGE | | PLACE OF BURIAL
CATHOLIC CEMETERY | |
| NAME OF PHYSICIAN
DR. J. J. CONNOLLY | | NAME OF MINISTER
REV. J. J. CONNOLLY | | NAME OF CLERGYMAN
REV. J. J. CONNOLLY | |
| NAME OF FUNERAL HOME
J. J. CONNOLLY | | NAME OF UNDERTAKER
J. J. CONNOLLY | | NAME OF CEMETERY
CATHOLIC CEMETERY | |
| NAME OF INTERVIEWER
J. J. CONNOLLY | | NAME OF REGISTRAR
J. J. CONNOLLY | | NAME OF CLERK
J. J. CONNOLLY | |
| NAME OF DECEASED'S MOTHER
MARY ELIZABETH | | NAME OF DECEASED'S FATHER
J. J. CONNOLLY | | NAME OF DECEASED'S SPOUSE
J. J. CONNOLLY | |
| NAME OF DECEASED'S BROTHER
J. J. CONNOLLY | | NAME OF DECEASED'S SISTER
MARY ELIZABETH | | NAME OF DECEASED'S CHILDREN
J. J. CONNOLLY | |
| NAME OF DECEASED'S GRANDFATHER
J. J. CONNOLLY | | NAME OF DECEASED'S GRANDMOTHER
MARY ELIZABETH | | NAME OF DECEASED'S UNCLE
J. J. CONNOLLY | |
| NAME OF DECEASED'S AUNT
MARY ELIZABETH | | NAME OF DECEASED'S NEPHEW
J. J. CONNOLLY | | NAME OF DECEASED'S NIECE
MARY ELIZABETH | |
| NAME OF DECEASED'S COUSIN
J. J. CONNOLLY | | NAME OF DECEASED'S FIRST COUSIN
MARY ELIZABETH | | NAME OF DECEASED'S SECOND COUSIN
J. J. CONNOLLY | |
| NAME OF DECEASED'S THIRD COUSIN
MARY ELIZABETH | | NAME OF DECEASED'S FOURTH COUSIN
J. J. CONNOLLY | | NAME OF DECEASED'S FIFTH COUSIN
MARY ELIZABETH | |
| NAME OF DECEASED'S SIXTH COUSIN
J. J. CONNOLLY | | NAME OF DECEASED'S SEVENTH COUSIN
MARY ELIZABETH | | NAME OF DECEASED'S EIGHTH COUSIN
J. J. CONNOLLY | |
| NAME OF DECEASED'S NINTH COUSIN
MARY ELIZABETH | | NAME OF DECEASED'S TENTH COUSIN
J. J. CONNOLLY | | NAME OF DECEASED'S ELEVENTH COUSIN
MARY ELIZABETH | |
| NAME OF DECEASED'S TWELFTH COUSIN
J. J. CONNOLLY | | NAME OF DECEASED'S THIRTEENTH COUSIN
MARY ELIZABETH | | NAME OF DECEASED'S FOURTEENTH COUSIN
J. J. CONNOLLY | |
| NAME OF DECEASED'S FIFTEENTH COUSIN
MARY ELIZABETH | | NAME OF DECEASED'S SIXTEENTH COUSIN
J. J. CONNOLLY | | NAME OF DECEASED'S SEVENTEENTH COUSIN
MARY ELIZABETH | |
| NAME OF DECEASED'S EIGHTEENTH COUSIN
J. J. CONNOLLY | | NAME OF DECEASED'S NINETEENTH COUSIN
MARY ELIZABETH | | NAME OF DECEASED'S TWENTIETH COUSIN
J. J. CONNOLLY | |

1062807

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02401

Reg. Dist. No.

| | | | |
|---|------------------------|--|--------------------------|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ohio b. COUNTY Summit | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN 1b Transient | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Akron 72x-3 | | d. STREET ADDRESS 5046 W. Bath Road, Rd.#7 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) enroute to Wash. Co. Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Grover Ernest Putman, jr. | | 4. DATE OF DEATH Month Day Year Feb. 8 19 59 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-22-35 |
| 9. AGE (In years last birthday) 23 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy | |
| 11. BIRTHPLACE (State or foreign country) North Dakota | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Grover Ernest Putman, Sr. | | 14. MOTHER'S MAIDEN NAME Barbara Langley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1952 to DOD | | 16. SOCIAL SECURITY NO. 280-28-3237 | |
| 17. INFORMANT Address Official Navy Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull
823x DUE TO Multiple fractured ribs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured(closed) rt tibia & fibula
DUE TO hemorrhage & shock (c)
INTERVAL BETWEEN ONSET AND DEATH 40 min | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lost control of automobile and ran into side abutment of bridge | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Feb. 8 59 1:30 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Funkstown Bridge | | 20f. (City or town) Hagerstown (County) Wash. (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) S. Robert Wells, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED Feb. 9 1959 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-16-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) Arlington (State) Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ernest S. Adams ADDRESS Adams Funeral Home, 4748 Wisc. Ave, NW, Wash. D.C. | | 24a. REC'D BY REGISTRAR DATE FEB 16 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Haul | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2399

CERTIFICATE OF DEATH

02402

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b
LIFE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
WASHINGTON COUNTY HOSPITAL | | | | d. STREET ADDRESS
45 EAST AVE. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First PAUL Middle EDGAR Last REECHER | | | | 4. DATE OF DEATH
Month FEBRUARY Day 17 Year 19 59 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/1/1921 | |
| 9. AGE (In years lost birthday)
37 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CONTRACTING OFFICER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. AIR FORCE | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
CHARLES R. REECHER | | | | 14. MOTHER'S MAIDEN NAME
MABEL REYNOLDS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, even unknown) YES (If yes, give year or date of service) W.W.#2 | | | | 16. SOCIAL SECURITY NO.
216-14-5841 | | 17. INFORMANT
MRS. GENEVIEVE REECHER | |
| Address HAGERSTOWN MD. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
2043 IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 14 Feb 1959 , to 17 Feb 1959 , that I last saw the deceased alive on 16 Feb 1959 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
F F Lusby | | | | ADDRESS (Street, city or town, state)
2301 N Potomac Hagerstown Md. | | | |
| DATE SIGNED
18 Feb 59 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
2/19/59 | | 22c. NAME OF CEMETERY OR CREMATORY
REST HAVEN CEM. | | 22d. LOCATION (City, town, or county) (State)
HAGERSTOWN MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. J. Thorment, Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 20 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2400

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Washington
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
1 month 20 days 03
Hagerstown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | d. STREET ADDRESS
331 Linganore Ave. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
HELEN
First Middle Last
LOUISE
REEL | | 4. DATE OF DEATH
Month Day Year
February
8
19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 14, 1907 |
| 9. AGE (In years last birthday)
51 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Hagerstown, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Coover Kniesley | | 14. MOTHER'S MAIDEN NAME
Bessie May Fiegley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Benjamin F. Reel
Address
Hagerstown, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma - Stomach
151X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
6 Mo. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 3 , 19 59 , to Feb. 8 , 19 59 , that I last saw the deceased alive on Feb. 8 , 19 59 , and that death occurred at M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
159 W. Washington St., Hagerstown, Md.
DATE SIGNED
2/9/59 | | | |
| ACTUAL SIGNATURE
Philip J. Hirshman
PHYSICIAN'S NAME (Type)
Philip J. Hirshman, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/11/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Suter-Pouzer Funeral Home
R. Franklin Pouzer
ADDRESS
Hagerstown, Md. | | 24a. REC'D BY REGISTRAR
DATE
FEB 13 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2401

CERTIFICATE OF DEATH

Reg. Dist. No. 02404

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>WASHINGTON</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HAGERSTOWN</u> | | | | c. LENGTH OF STAY IN 1b
<u>4 HOURS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>WASH. CO. HOSPITAL</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>GARY</u> Middle <u>EDWIN</u> Last <u>REESE</u> | | | | 4. DATE OF DEATH
Month <u>FEBRUARY</u> Day <u>7</u> Year <u>1959</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>FEBRUARY 6 1959</u> | |
| 9. AGE (In years last birthday) yrs. <u>4</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>HAGERSTOWN MD.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>MARVIN REESE</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>OTHELIA E. RIDENOUR</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]
<u>NO</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>NONE</u> | | | | 17. INFORMANT
<u>MARVIN REESE BOONSBORO MD. R.2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Premature</u>
<u>776X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____
DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 hrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Feb-6</u> , 19 <u>59</u> , to <u>Feb-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb-6</u> , 19 <u>59</u> , and that death occurred at <u>2 A</u> . M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>G. W. L. Van</u> | | | | ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>2/7/59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>G. W. L. Van</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>FEB. 7 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>BOONSBORO CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BOONSBORO WASH. CO. MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John H. Bass</u> | | | | ADDRESS
<u>Boonsboro Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 10 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Charles E. Kline</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2430

CERTIFICATE OF DEATH

Reg. Dist. No.

02405

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SAN MAR RURAL | | | | c. LENGTH OF STAY IN 1b
4 Yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
FAHRNEY KEEDY MEMORIAL HOME | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First SARAH Middle E. Last RINEHART | | | | 4. DATE OF DEATH
Month FEBRUARY Day 9 Year 1959 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
OCTOBER 3 1873 | |
| 9. AGE (In years last birthday)
85 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
WILLIAM CULBERTSON | | | | 14. MOTHER'S MAIDEN NAME
EMMA LEIDIG | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NO | | 17. INFORMANT
ESTER P. SEAL WOODLAWN MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized arteriosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Haemorrhage
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
7 yrs
3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 4 , 19 59 , to Feb 9 , 19 59 , that I last saw the deceased alive on Feb 8 , 19 59 , and that death occurred at 8 A . M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Baltimore DATE SIGNED 2/9/59
ACTUAL SIGNATURE G. W. Lehn M.D. Ind.
PHYSICIAN'S NAME (Type) G. W. Lehn | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
FEB. 12 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
MT. ZION CEMETERY | | 22d. LOCATION (City, town, or county) (State)
Lothian AAcco. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John D. Stansbury | | | | 24a. REC'D BY REGISTRAR
DATE FEB 13 1959 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanks | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02406

2402

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Washington
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN IB
3 Weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Wash County Hospital | | /d. STREET ADDRESS
Box 67 | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
IMA FAYE ROHRER | | 4. DATE OF DEATH
Month February Day 21 Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 9 1907 |
| 9. AGE (In years last birthday)
51 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk in Engineering | | 10b. KIND OF BUSINESS OR INDUSTRY
Fairchild | |
| 11. BIRTHPLACE (State or foreign country)
San Mar Wash Co Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Martin S. Smith | | 14. MOTHER'S MAIDEN NAME
Carrie L. Welty | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-09-9834 | |
| 17. INFORMANT
Dale B. Rohrer | | Address
Chewsville Wash. Co Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatous generalized
170X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of breast DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
20g. INTERVAL BETWEEN ONSET AND DEATH
sev weeks
sev month | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that I attended the deceased from 2/3/59 , 19____, to 2/21/59 , 19____, that I last saw the deceased alive on 2/20/59 , 19____, and that death occurred at 5 A. M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
136 North Potomac St., 2/23/59 | | | |
| ACTUAL SIGNATURE
Howard N. Weeks, M.D. | | M.D. 136 North Potomac St., 2/23/59 | |
| PHYSICIAN'S NAME (Type)
Howard N. Weeks, M.D. | | Hagerstown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
2/23/59 | 22c. NAME OF CEMETERY OR CREMATORY
Smithsburg Cemetery | 22d. LOCATION (City, town, or county) (State)
Smithsburg Wash. Co Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Andrew K. Coffman | | 24a. REC'D BY REGISTRAR
FEB 24 1959 | |
| ADDRESS
Hagerstown Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2403

CERTIFICATE OF DEATH

Reg. Dist. No.

02407

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
5 weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Aletha Last Roulette | | | | 4. DATE OF DEATH
Month Feb. Day 10 Year 1959 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 5 1896 | |
| 9. AGE (In years last birthday) yrs. 62 | | IF UNDER 1 YEAR
Months 3 Days 3 | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Riveter | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Aircraft | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A | | | | | | | |
| 13. FATHER'S NAME
Theodore Smith | | | | 14. MOTHER'S MAIDEN NAME
Minnie Davis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | | | 16. SOCIAL SECURITY NO. 216 14 6289 | | | |
| 17. INFORMANT
Mrs. Howard Swain | | | | Address
Sharpsburg Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the gallbladder & Liver
155.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 1 yr(?) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Jan. 1 , 19 58 , to Feb. 10 , 19 59 , that I last saw the deceased alive on 2/10/59 2/9/59 , and that death occurred at 3:05 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. H. Shealy | | | | ADDRESS (Street, city or town, state) Sharpsburg, Md. | | | |
| PHYSICIAN'S NAME (Type) W. H. Shealy M. D. | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 12-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. View Cemetery | | 22d. LOCATION (City, town, or county) (State)
Sharpsburg Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Albert L. Leaf Williamsport, Md. | | | | ADDRESS | | | |
| 24a. REC'D BY REGISTRAR
DATE FEB 16 59 | | | | 24b. REGISTRAR'S SIGNATURE
Carlton L. Knapp | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2404

CERTIFICATE OF DEATH

02408

Reg. Dist. No.

| | | | | | | | |
|---|--|--|-----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MATYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | | c. LENGTH OF STAY IN 1b LIFE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | | e. STREET ADDRESS 930A LANVALE ST. | | | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First FREDERICK Middle COOKERLEY Last SCHLEIGH | | | | 4. DATE OF DEATH Month FEBRUARY Day 21 Year 19 59 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/22/1896 | | 9. AGE (In years last birthday) 62 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY BLDG. CONTRACTOR | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM L. SCHLEIGH | | | | 14. MOTHER'S MAIDEN NAME IDA VIRGINIA ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-09-9316 | | 17. INFORMANT MRS. BONNIE SCHLEIGH | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left upper lobe with metastasis to bone, liver, kidneys, and adrenals.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 162.1 (c) 5 weeks (certain)
DUE TO
(b) 162.1 (c) 5 weeks (certain) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from January 17, 1959 , to February 21, 1959 , that I last saw the deceased alive on February 20, 1959 , and that death occurred at 9:45 A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. DATE SIGNED 2/23/59 | | | | | | | |
| ACTUAL SIGNATURE W. T. Layman, M.D. | | M.D. 100 Professional Arts Bldg. DATE SIGNED 2/23/59 | | | | | |
| PHYSICIAN'S NAME (Type) William T. Layman | | Hagerstown | | Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 2/24/59 | 22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM. | | 22d. LOCATION (City, town, or county) HAGERSTOWN | | (State) MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. J. Herment, Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR FEB 25 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. House | |

2405

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | d. STREET ADDRESS
166 North Ave. | |
| 3. NAME OF DECEASED (Type or print)
TODD ANTHONY SCHLEIGH | | 4. DATE OF DEATH
February 10 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 25, 1959 |
| 9. AGE (In years last birthday)
15 | | IF UNDER 1 YEAR
Months 15 Days 15 Hours 15 Min. 15 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11. BIRTHPLACE (State or foreign country)
Hagerstown, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert G. Schleigh | | 14. MOTHER'S MAIDEN NAME
Patsy Hull | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Mr. Robert G. Schleigh | | Address
Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7546 Congestive Heart Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery of the aorta
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
at birth |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 1/25, 1959 , to 2/10, 1959 , that I last saw the deceased alive on 2/10, 1959 , and that death occurred at 12:40 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
H. D. Bowman, M.D. | | ADDRESS (Street, city or town, state)
318 N. Plummer St. Hagerstown, Md. | |
| DATE SIGNED
2/10/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/11/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
R. Franklin Dwyer | | 24a. REC'D BY REGISTRAR
FEB 13 '59 | |
| ADDRESS
Hagerstown, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Journal of Management Education 26(8)

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

2406

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02410

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b
03212x Hagerstown
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 118 W. Antietam Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Faith Middle Louise Last Shafer | | 4. DATE OF DEATH
Month Feb. Day 7 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1925 |
| 9. AGE (In years last birthday) 33 yrs. | | 10. IF UNDER 1 YEAR
Months 33 Days 33 Hours 33 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant - Proprietor | | 10b. KIND OF BUSINESS OR INDUSTRY Berkley County W. Va. | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Edward J. Boward | | 14. MOTHER'S MAIDEN NAME Nellie M. Starliper | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Franklin E. Shafer, Jr
Address Hagerstown, Md | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun Shot (20gauge) wound into abdomen
981X DUE TO Hemorrhage and shock
Conditions, if any, which gave rise to immediate cause (b) -
(c) -
(a), stating the underlying cause lost. (c) - | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Shot in abdomen by husband | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in abdomen by husband | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 9:00 a.m. Feb. 7 1959 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Restaurant | | 20f. (City or town) Hagerstown (County) Wash (State) Md | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE S. Robert Wells
EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED 2-7-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/10/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Spring Mill Cemetery | | 22d. LOCATION (City, town, or county) Berkeley Co. W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard K Brown
ADDRESS Martinsburg W. Va. | | 24a. REC'D BY REGISTRAR FEB 10 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02411

Reg. Dist. No.

2407

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN 1b 20 YRS. | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
d. STREET ADDRESS 1163 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First FRANKLIN Middle ELLSWORTH Last SHAFAER JR. | | | 4. DATE OF DEATH
Month FEBRUARY Day 8 Year 19 59 | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/28/1922 | 9. AGE (In years last birthday)
36 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ASSEMBLER | | 10b. KIND OF BUSINESS OR INDUSTRY
AIRCRAFT CO. | | 11. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
FRANKLIN E. SHAFAER SR. | | | 14. MOTHER'S MAIDEN NAME
ALICE DRILL | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name and unit) YES W.W.#2 | | 16. SOCIAL SECURITY NO.
214-14-6111 | | 17. INFORMANT
MRS. ALICE SHAFAER
Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun shot into chest in cardiac region (16 gauge shotgun)
DUE TO 976x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Shot self with 16 gauge shotgun after having shot wife | | | |
| 20c. TIME OF INJURY
Hour 8:00 Minute XX p. m. 2-8-1959 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
In Automobile | 20f. (City or town)
Hagerstown | (County)
Wash | (State)
Md |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
2-10-59 | |
| EXAMINER'S NAME (Type)
S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
2/11/59 | 22c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEM. | | 22d. LOCATION (City, town, or county)
HAGERSTOWN MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. J. Korment, Hagerstown, Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 13 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kane | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2207

| | | | | | | | | | |
|-----------------------------------|--|----------------------------|--|---------------------------|--|----------------------------|--|--------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | |
| 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. TIME OF DEATH | | 10. PLACE OF DEATH | |
| 11. CAUSE OF DEATH | | 12. MANNER OF DEATH | | 13. SIGNATURE OF EXAMINER | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF CORONER | |
| 16. SIGNATURE OF MEDICAL EXAMINER | | 17. SIGNATURE OF WITNESSES | | 18. SIGNATURE OF CORONER | | 19. SIGNATURE OF JURY | | 20. SIGNATURE OF JUDGE | |
| 21. SIGNATURE OF JURY | | 22. SIGNATURE OF JUDGE | | 23. SIGNATURE OF JURY | | 24. SIGNATURE OF JUDGE | | 25. SIGNATURE OF JURY | |
| 26. SIGNATURE OF JUDGE | | 27. SIGNATURE OF JURY | | 28. SIGNATURE OF JUDGE | | 29. SIGNATURE OF JURY | | 30. SIGNATURE OF JUDGE | |
| 31. SIGNATURE OF JURY | | 32. SIGNATURE OF JUDGE | | 33. SIGNATURE OF JURY | | 34. SIGNATURE OF JUDGE | | 35. SIGNATURE OF JURY | |
| 36. SIGNATURE OF JUDGE | | 37. SIGNATURE OF JURY | | 38. SIGNATURE OF JUDGE | | 39. SIGNATURE OF JURY | | 40. SIGNATURE OF JUDGE | |
| 41. SIGNATURE OF JURY | | 42. SIGNATURE OF JUDGE | | 43. SIGNATURE OF JURY | | 44. SIGNATURE OF JUDGE | | 45. SIGNATURE OF JURY | |
| 46. SIGNATURE OF JUDGE | | 47. SIGNATURE OF JURY | | 48. SIGNATURE OF JUDGE | | 49. SIGNATURE OF JURY | | 50. SIGNATURE OF JUDGE | |
| 51. SIGNATURE OF JURY | | 52. SIGNATURE OF JUDGE | | 53. SIGNATURE OF JURY | | 54. SIGNATURE OF JUDGE | | 55. SIGNATURE OF JURY | |
| 56. SIGNATURE OF JUDGE | | 57. SIGNATURE OF JURY | | 58. SIGNATURE OF JUDGE | | 59. SIGNATURE OF JURY | | 60. SIGNATURE OF JUDGE | |
| 61. SIGNATURE OF JURY | | 62. SIGNATURE OF JUDGE | | 63. SIGNATURE OF JURY | | 64. SIGNATURE OF JUDGE | | 65. SIGNATURE OF JURY | |
| 66. SIGNATURE OF JUDGE | | 67. SIGNATURE OF JURY | | 68. SIGNATURE OF JUDGE | | 69. SIGNATURE OF JURY | | 70. SIGNATURE OF JUDGE | |
| 71. SIGNATURE OF JURY | | 72. SIGNATURE OF JUDGE | | 73. SIGNATURE OF JURY | | 74. SIGNATURE OF JUDGE | | 75. SIGNATURE OF JURY | |
| 76. SIGNATURE OF JUDGE | | 77. SIGNATURE OF JURY | | 78. SIGNATURE OF JUDGE | | 79. SIGNATURE OF JURY | | 80. SIGNATURE OF JUDGE | |
| 81. SIGNATURE OF JURY | | 82. SIGNATURE OF JUDGE | | 83. SIGNATURE OF JURY | | 84. SIGNATURE OF JUDGE | | 85. SIGNATURE OF JURY | |
| 86. SIGNATURE OF JUDGE | | 87. SIGNATURE OF JURY | | 88. SIGNATURE OF JUDGE | | 89. SIGNATURE OF JURY | | 90. SIGNATURE OF JUDGE | |
| 91. SIGNATURE OF JURY | | 92. SIGNATURE OF JUDGE | | 93. SIGNATURE OF JURY | | 94. SIGNATURE OF JUDGE | | 95. SIGNATURE OF JURY | |
| 96. SIGNATURE OF JUDGE | | 97. SIGNATURE OF JURY | | 98. SIGNATURE OF JUDGE | | 99. SIGNATURE OF JURY | | 100. SIGNATURE OF JUDGE | |

CERTIFICATE OF DEATH

Reg. Dist. No.

2408

02412

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>WASHINGTON</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>PR. Geo.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Hill</u> 16X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Western Md. Hospital For Incurables</u> | | d. STREET ADDRESS
<u>4000 - St. Barnabas Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>BERTIE</u> Middle <u>CECIL</u> Last <u>SHIPMAN</u> | | 4. DATE OF DEATH <u>Feb.</u> Month <u>23</u> Day <u>19</u> Year <u>59</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 7 - 1903</u> |
| 9. AGE (In years last birthday)
<u>55</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Auto Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Samuel Shipman</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Wenner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>578-09-3464</u> | |
| 17. INFORMANT
<u>Rosa Lee Shipman</u> | | Address
<u>4000 - St. Barnabas Rd. SE.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA, bilateral</u>
DUE TO (b) <u>METASTASIS LESION TO BRAIN STEM</u>
DUE TO (c) <u>CARCINOMA OF THE PHARYNX</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>5 MONTHS</u>
<u>2 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>DEC. 4</u> , 19 <u>58</u> , to <u>FEB. 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>FEB. 23</u> , 19 <u>59</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Euaristo R Laddizabal</u> | | DATE SIGNED <u>2-24-59</u> | |
| PHYSICIAN'S NAME (Type) <u>Euaristo R Laddizabal</u> | | <u>Hagerstown Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
<u>Feb 26th</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Silver Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Smithland Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Lemmons Bros.</u> | | 24a. REC'D BY REGISTRAR
<u>1661 - Good Hope Rd SE</u> | 24b. REGISTRAR'S SIGNATURE
<u>Carroll E. King</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2408

Washington

Hygiene Town

1st Ward

Western and Hospital for Infectious

61
x

Male white

East Main

Shannon Thompson

328-01-244 Rosa Lee Thompson

Eighty seven

Seventy

31.4.4

July 1-1902 20

4000-12-1-1902

Silver Hill

and

P.R. Co.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02413

Item 7 Film G228 2-16-59 et

2431

| | | | | | | | |
|--|--|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Hagerstown R#5 | | c. LENGTH OF STAY IN 1b
40 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<input checked="" type="checkbox"/> Rural Hagerstown, Md. R#5 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
----- | | | | d. STREET ADDRESS
----- | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First SAMUEL Middle NELSON Last SIMPSON | | | | 4. DATE OF DEATH
Month Feb. Day 9 Year 1959 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 30, 1875 | | 9. AGE (In years last birthday)
83 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farm Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Agriculture | | 11. BIRTHPLACE (State or foreign country)
Mercersburg, Penna. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Not Known | | | | 14. MOTHER'S MAIDEN NAME
Not Known | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mr. F. L. Stockslager Address Hagerstown, Md. R#5 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease
422.1 DUE TO with myocardial failure grade IV
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
none | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. none 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
None | | 20f. (City or town)
----- | | (County)
----- | (State)
----- |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE S. Robert Wells | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/12/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Church Of God Cemetery | | 22d. LOCATION (City, town, or county) (State)
Blairs Valley (Clearspring) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Rest Haven Funeral Chapel Inc. Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 13 '59 | | 24b. REGISTRAR'S SIGNATURE
William C. Horst. U. Pres. | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BATH HOUSE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|-----|--|-----|--|------|--|----------|--|----------|--|-----------|--|------------|--|-----------|--|---------------|--|---------------|--|----------------|--|----------------|--|-----------------|--|-----------------------|--|---------------------|--|----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | RESIDENCE | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2432

CERTIFICATE OF DEATH

02414

Reg. Dist. No.

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN 1b LIFE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) MARTIN MANOR REST HOME | | d. STREET ADDRESS 245 MILL ST. | |
| 3. NAME OF DECEASED (Type or print) JOHN First WALTER Middle SMITH Last | | 4. DATE OF DEATH FEBRUARY 13 19 59 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH UNKNOWN |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY MOVING & STORAGE CO. MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN O. SMITH | | 14. MOTHER'S MAIDEN NAME SARAH C. WALTER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) NO | | 16. SOCIAL SECURITY NO. 217-10-2544 | |
| 17. INFORMANT MISS CATHERINE W. EMBREY | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 coronary thrombosis
DUE TO (b) arteries clogged
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH instant years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/4/59 19 to 2/13/59 19 that I last saw the deceased alive on 2/11/59 19 and that death occurred at 8:00 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Howard N. Weeks | | ADDRESS (Street, city or town, state) 136 N. Potomac Street DATE SIGNED 2/14/59 | |
| PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. | | Hagerstown, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 2/15/59 | 22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | 22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE A. J. Korman, Hagerstown, Md | | 24a. REC'D BY REGISTRAR DATE FEB 16 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kross | | | |

CERTIFICATE OF DEATH

2132

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|---------------------------------------|--|--------------------------------------|--|------------------------------------|--|--|--|---|--|
| 1. NAME OF DECEASED
JAMES C. BAKER | | 2. SEX
Male | | 3. AGE
65 | | 4. DATE OF DEATH
Jan 15 1918 | | 5. PLACE OF DEATH
Home | |
| 6. OCCUPATION
Farmer | | 7. CAUSE OF DEATH
Heart Disease | | 8. MANNER OF DEATH
Natural | | 9. SIGNATURE OF PHYSICIAN
J. H. Smith | | 10. SIGNATURE OF REGISTRAR
J. H. Smith | |
| 11. PLACE OF BIRTH
Maryland | | 12. DATE OF BIRTH
Jan 1 1853 | | 13. COLOR
White | | 14. HEIGHT
5' 8" | | 15. WEIGHT
160 lbs | |
| 16. EDUCATION
High School | | 17. RELIGION
Methodist | | 18. MARITAL STATUS
Married | | 19. PREVIOUS ILLNESS
None | | 20. OTHER NOTES
None | |
| 21. SIGNATURE OF DECEASED
None | | 22. SIGNATURE OF NEXT OF KIN
None | | 23. SIGNATURE OF WITNESSES
None | | 24. SIGNATURE OF CLERK
None | | 25. SIGNATURE OF PHYSICIAN
None | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

2433

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bureau of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| 1. PLACE OF DEATH
a. COUNTY <u>Washington</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown R # 5</u> | | c. LENGTH OF STAY IN 1b
<u>30 Yrs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Leitersburg Pike</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>WILLIAM</u> Middle <u>W</u> Last <u>SMITH</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>3</u> Year <u>1959</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>October 5 1889</u> |
| 9. AGE (in years last birthday)
<u>69</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 12. KIND OF BUSINESS OR INDUSTRY
<u>Own Farm</u> | |
| 13. BIRTHPLACE (State or foreign country)
<u>Foxville Fred Co Md.</u> | | 14. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 15. FATHER'S NAME
<u>William H. Smith</u> | | 16. MOTHER'S MAIDEN NAME
<u>Mary Baker</u> | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 18. SOCIAL SECURITY NO.
<u>none</u> | |
| 19. INFORMANT
<u>Etta K. Smith Hagerstown Md. R # 5</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(a), stating the underlying cause lost. (c) <u> </u> DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>none</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u> </u>
<u>none</u> <u>19</u> | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>none</u> | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/6/59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Bethel Cemetery</u> |
| | | 22d. LOCATION (City, town, or county) (State)
<u>near Foxville Fred Co Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Andrew K. Coffman Hagerstown Md.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraw</u> | |
| 24c. REC'D BY REGISTRAR
DATE <u>FEB 9 '59</u> | | | |

2403

02416

CERTIFICATE OF DEATH

Reg. Dist. No. 302

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN TB
5 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | e. STREET ADDRESS
1901 Jefferson Boulevard | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle WILLIAM Last SODERGREN | | 4. DATE OF DEATH
Month February Day 18 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 8, 1908 |
| 9. AGE (In years last birthday)
50 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Timekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 11. BIRTHPLACE (State or foreign country)
Hagerstown, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Johann V. Sodergren | | 14. MOTHER'S MAIDEN NAME
Lucy Groot | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes W.W. II | | 16. SOCIAL SECURITY NO.
Mrs. Margeurite Sodergren Hagerstown, Md. | |
| 17. INFORMANT
Mrs. Margeurite Sodergren Hagerstown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Nephrosclerosis
446X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
16 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hypertensive vascular disease | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 30, 1957, to Feb. 18, 1959 , that I last saw the deceased alive on Feb. 18, 1959 , and that death occurred at 1:55P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE B. B. Kneisley | | ADDRESS (Street, city or town, state) DATE SIGNED 2/20/59 | |
| PHYSICIAN'S NAME (Type) Dr. B. B. Kneisley | | Hagerstown, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/21/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Suter-Rouzer Funeral Home
R. Franklin Rouzer | | 24a. REC'D BY REGISTRAR
DATE FEB 24 '59 | |
| ADDRESS
Hagerstown, Md. | | 24b. REGISTRAR'S SIGNATURE
C. L. H. H. H. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

302

Washington

Washington

1900

Washington

1901 Jefferson Boulevard

Washington County Hospital

February

February

February

February

June 8, 1903

White

Washington, D.C.

Washington

Washington

of 1903

of 1903

of 1903

of 1903

Washington

Washington

Washington

Washington

Washington

Washington

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02417

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg | c. LENGTH OF STAY IN 1b 4 yrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Smithsburg, | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 68 S. Main Street | | d. STREET ADDRESS 68 S. Main Street | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Jane Middle Foltz Last Spitzer | | 4. DATE OF DEATH Month Feb 13 Day 19 Year 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Jan. 10, 1916 |
| 9. AGE (In years last birthday) 45 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress Making | | 10b. KIND OF BUSINESS OR INDUSTRY L'Aigalon | |
| 11. BIRTHPLACE (State or foreign country) Leitersburg, Md | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Harvey C. Albin | | 14. MOTHER'S MAIDEN NAME Lucy E. Foltz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-24-9086 | |
| 17. INFORMANT Catherine L. Delauter- Daughter | | Address Cavetown, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 974X Suffocation by hanging
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self with rope from water pipe at her home | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. Feb 13 1959 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Smithsburg, Wash (County) Md (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 2-16-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-18-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Garden | | 22d. LOCATION (City, town, or county) Hagerstown, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md. | | 24a. REC'D BY REGISTRAR DATE FEB 19 59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraw | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2410

CERTIFICATE OF DEATH

02418

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. STREET ADDRESS 38 East Ave
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Edgar Lemuel Strock
First Middle Last | | 4. DATE OF DEATH February 20 19 59
Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 27, 1888
9. AGE (In years last birthday) 71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Hagerstown, Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Willoughby Strock | | 14. MOTHER'S MAIDEN NAME Louise Stockslager | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-14-7040 | |
| 17. INFORMANT Mrs Ava M Strock
Address 38 East Ave. Hagerstown, Md | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis
DUE TO (c) Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 1947 , to Feb. 20 1959 , that I last saw the deceased alive on Feb. 19 1959 , and that death occurred at 3:50 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown, Md. DATE SIGNED 2/20/59 | | | |
| ACTUAL SIGNATURE Lloyd A. Hoffman M.D. | | PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 22/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown, Md | | 24a. REC'D BY REGISTRAR FEB 24 1959 DATE | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Evans | | | |

CERTIFICATE OF DEATH

1910

FILE NO.

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BUILDING

DATE OF ENTRY INTO LOT

DATE OF ENTRY INTO TRACT

DATE OF ENTRY INTO PARCEL

DATE OF ENTRY INTO ACRES

DATE OF ENTRY INTO SQUARES

DATE OF ENTRY INTO PERCHES

DATE OF ENTRY INTO FEET

DATE OF ENTRY INTO INCHES

DATE OF ENTRY INTO FATHOMS

DATE OF ENTRY INTO MILES

DATE OF ENTRY INTO SEASONS

DATE OF ENTRY INTO YEARS

DATE OF ENTRY INTO MONTHS

DATE OF ENTRY INTO DAYS

DATE OF ENTRY INTO HOURS

DATE OF ENTRY INTO MINUTES

DATE OF ENTRY INTO SECONDS

DATE OF ENTRY INTO TENTHS

DATE OF ENTRY INTO HUNDRETHS

DATE OF ENTRY INTO THOUSANDTHS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2435
CERTIFICATE OF DEATH

Reg. Dist. No.

02419

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dargan (Rural) | | c. LENGTH OF STAY IN 1b
Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Residence | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle HENRY Last TAYLOR | | 4. DATE OF DEATH
Month February Day 22 Year 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 8, 1871 |
| 9. AGE (In years last birthday)
87 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter (Ret.) | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (State or foreign country)
Dargan, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
David Francis Taylor | | 14. MOTHER'S MAIDEN NAME
Ellen Jane Wilders | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) NONE | | 16. SOCIAL SECURITY NO.
236-14-4580 | |
| 17. INFORMANT
Mr. Donald E. Taylor | | RFD # 1, Harpers Ferry, West Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized arteriosclerosis
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO
(c) <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abdominal tumor - type undiagnosed. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 20, 1958 , to 2/22, 1959 , that I last saw the deceased alive on Feb. 20, 1959 , and that death occurred at M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Walter H. Shealy | | M.D. Sharpesburg, Md. 2/24/59 | |
| PHYSICIAN'S NAME (Type)
Walter H. Shealy | | Sharpesburg, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-24-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Samples Manor Cem. | | 22d. LOCATION (City, town, or county) (State)
Samples Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. E. Eachus | | ADDRESS
Box 35, Harpers Ferry, W. Va. | |
| 24a. REC'D BY REGISTRAR
DATE FEB 26 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hawk | |

2411

CERTIFICATE OF DEATH

02420

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | | | c. LENGTH OF STAY IN 1b
Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Washington County Hospital | | | | d. STREET ADDRESS
123 Randolph Ave. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle FRANKLIN Last THOMAS JR | | | | 4. DATE OF DEATH
Month Feb. Day 6 Year 19 59 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 18, 1959 | | 9. AGE (In years last birthday) yrs.
18 | IF UNDER 1 YEAR
Months 18 Days 18 | IF UNDER 24 HRS.
Hours 18 Min. 18 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Hagerstown, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert F. Thomas | | | | 14. MOTHER'S MAIDEN NAME
Hazel R. Alter | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Robert F. Thomas 123 Randolph Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital Heart Disease
754.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia + atelectasis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 1/2 weeks |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2 Feb , 19 59 , to 6 Feb , 19 59 , that I last saw the deceased alive on 5 Feb , 19 59 , and that death occurred at 4:25 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 2301 N Potomac Hagerstown Md.
DATE SIGNED 6 Feb 59
ACTUAL SIGNATURE F.F. Lusby
PHYSICIAN'S NAME (Type) F.F. Lusby | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2/8/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Rest Haven Funeral Chapel Inc. Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR
DATE FEB 9 '59 | | 24b. REGISTRAR'S SIGNATURE
Clifford L. K... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. A. Horst - J. P. 2081315xv3

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAGERSTOWN 2103.2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
JACKSON CONVALESCENT HOME | | d. STREET ADDRESS
526 BROWN AVENUE | |
| 3. NAME OF DECEASED (Type or print)
First MAUDE Middle C. Last WACHTER | | 4. DATE OF DEATH
Month FEBRUARY Day 22 Year 1959 19 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JANUARY 17 1885 74 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | 11. BIRTHPLACE (State or foreign country)
BOONSBORO WASH.CO.MD. |
| 13. FATHER'S NAME
SAMUEL E. YOUNG | | 14. MOTHER'S MAIDEN NAME
ELLA B. COST | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
219-26-1846 | |
| 17. INFORMANT
MISS EVELYN WACHTER | | Address 526 BROWN AVE. HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus
DUE TO Hemiplegia
(c) Disability
INTERVAL BETWEEN ONSET AND DEATH 4 weeks - 9 mos. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May , 19 58 , to February 19 , 19 59 , that I last saw the deceased alive on Feb. 21 , 19 59 , and that death occurred at 2:45 AM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) M.D. 159 W. Washington St., Hagerstown, Md. DATE SIGNED 2/23/59 | | | |
| ACTUAL SIGNATURE Philip J. Hirshman | | PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
FEB. 24 1959 | 22c. NAME OF CEMETERY OR CREMATORY
BOONSBORO CEMETERY | 22d. LOCATION (City, town, or county) (State)
BOONSBORO WASH.CO.MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John C. Bad | | 24a. REC'D BY REGISTRAR
DATE FEB 26 '59 | 24b. REGISTRAR'S SIGNATURE
Charles S. Fries |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02422

| | | | | | |
|---|---------------------------|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Washington | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Maugansville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
DOA - Washington County Hospital | | | | d. STREET ADDRESS
/ - | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle W Last Weaver | | 4. DATE OF DEATH
Month Feb. 25 Day 19 Year 59 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 7, 1889 | 9. AGE (In years last birthday)
69 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Grain Elevator Co. | | 11. BIRTHPLACE (State or foreign country)
Greencastle Pa. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Martin L Weaver | | | |
| 14. MOTHER'S MAIDEN NAME
Clara Walck | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | | |
| 16. SOCIAL SECURITY NO.
214-03-7329 | | 17. INFORMANT
Mrs. Hattie Weaver- Maugansville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Arterioscleotic coronary heart disease
DUE TO Acute coronary thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
None 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | |
| 20f. (City or town)
- - - | | 20g. (County)
- - - | | 20h. (State)
- - - | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
S. Robert Wells | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
2-26-59 | |
| EXAMINER'S NAME (Type)
S. Robert Wells, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-28-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Reiff Cemetery | |
| 22d. LOCATION (City, town, or county)
Cearfoss, Maryland | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
A. E. Minnick | | ADDRESS
Greencastle, Pa. | | 24a. REC'D BY REGISTRAR
DATE MAR 3 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|---|--|---------------------------|------------------------------------|--|--|---------------------------------|--|--|--|
| Countersigned D.M. E. | | | | | | | | | |
| FEB 22 1959 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 02423 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Washington County</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>FREDERICK</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Interpeterstown</u> | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (LANCE)</u> 10X-2 | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hosp.</u> | | | | | d. STREET ADDRESS <u>Near Middleton, Md.</u> <input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Thomas Lafayette Winfield, Jr.</u> | | | | | 4. DATE OF DEATH
Month <u>2</u> Day <u>21</u> Year <u>1959</u> | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4/29/58</u> | | 9. AGE (In years last birthday) <u>9 mos.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 13. FATHER'S NAME <u>Thomas Lafayette Winfield, Sr.</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine West</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | | |
| 17. INFORMANT <u>Thomas Winfield Sr.</u> | | | | | Address <u>—</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Adrenal Insufficiency</u>
<u>057.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute hemorrhagic disease</u> DUE TO
(c) <u>(Waterhouse-Friderichsen Syndrome)</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. p. <u>—</u> m. <u>—</u> 19 <u>—</u> | | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from <u>2/21</u> , 1959, to <u>2/21</u> , 1959, that I last saw the deceased alive on <u>2/21</u> , 1959, and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE <u>Richard A. Young</u> | | | | | ADDRESS (Street, city or town, state) <u>101 King Street</u> DATE SIGNED <u>2/21/59</u> | | | | |
| PHYSICIAN'S NAME (Type) <u>Richard A. Young</u> | | | | | M.D. <u>Interpeterstown, Md.</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 22b. DATE THEREOF <u>2-24-1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel U. S. Cem.</u> | | | 22d. LOCATION (City, town, or county) (State) <u>FREDERICK Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Blashell Co., Middletown, Md.</u> | | | | | 24a. REC'D BY REGISTRAR <u>FEB 25 59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | | |

2081202 XVS

CERTIFICATE OF DEATH

| | | |
|---|--|---|
| DEATH OF
NAME
SEX
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
MARITAL STATUS
COLOR OF SKIN
BUILDING
COMPLEXION
HAIR
EYES
TENDRILS
TEETH
NAILS
SKIN
TONGUE
THROAT
LUNGS
HEART
LIVER
SPLEEN
PANCREAS
STOMACH
SMALL INTESTINE
LARGE INTESTINE
RECTUM
UTERUS
VAGINA
TESTES
PROSTATE
BLADDER
URETERS
KIDNEYS
ADRENALS
THYROID GLAND
PARATHYROID GLANDS
PITUITARY GLAND
HYPOTHYROID GLAND
THYMUS GLAND
PANCREAS
SALIVARY GLANDS
LARYNX
TRACHEA
BRONCHI
LUNGS
HEART
LIVER
SPLEEN
PANCREAS
STOMACH
SMALL INTESTINE
LARGE INTESTINE
RECTUM
UTERUS
VAGINA
TESTES
PROSTATE
BLADDER
URETERS
KIDNEYS
ADRENALS
THYROID GLAND
PARATHYROID GLANDS
PITUITARY GLAND
HYPOTHYROID GLAND
THYMUS GLAND | | CAUSE OF DEATH
DIRECT
INDIRECT
MANNER OF DEATH
PLACE OF DEATH
TIME OF DEATH
DATE OF DEATH
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF PHYSICIAN
SIGNATURE OF MINISTER OF THE GOSPEL
SIGNATURE OF CLERGYMAN
SIGNATURE OF CHURCH WARDEN
SIGNATURE OF BURIAL PLACE
SIGNATURE OF FUNERAL HOME
SIGNATURE OF CEMETERY
SIGNATURE OF STATE DEPARTMENT OF HEALTH |
|---|--|---|

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2415

CERTIFICATE OF DEATH

Reg. Dist. No.

02424

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. LENGTH OF STAY IN 1b
DOA | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Wash. Co. Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Truman Middle L Last Wolf | | 4. DATE OF DEATH
Month 2 Day 28 Year 19 59 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-1-1887 |
| 9. AGE (In years last birthday) yrs. 71 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
self employed | |
| 11. BIRTHPLACE (State or foreign country)
Boonsboro, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Frank Wolf | | 14. MOTHER'S MAIDEN NAME
Laura Martz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
214-09-6168 | |
| 17. INFORMANT
Mrs. Laura Wolf | | Address
Hagerstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.
(b) Atheromatous Cardiovascular Disease.
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None. | | | INTERVAL BETWEEN ONSET AND DEATH
3 hours.
2 years. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Feb. 28, 19 59 , to Feb. 28, 19 59 , that I last saw the deceased alive on Feb. 28, 19 59 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 119 North Potomac Street, 3-2-59
DATE SIGNED _____
ACTUAL SIGNATURE R.A. Bell
PHYSICIAN'S NAME (Type) R.A. Bell, M.D. Hagerstown, Maryland. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 22b. DATE THEREOF
3-3-59 | 22c. NAME OF CEMETERY OR CREMATORY
Boonsboro | 22d. LOCATION (City, town, or county) (State)
Boonsboro, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Fred W. Kraiss | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Krauss | |
| ADDRESS
Hagerstown, Md. | | DATE MAR 4 '59 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

